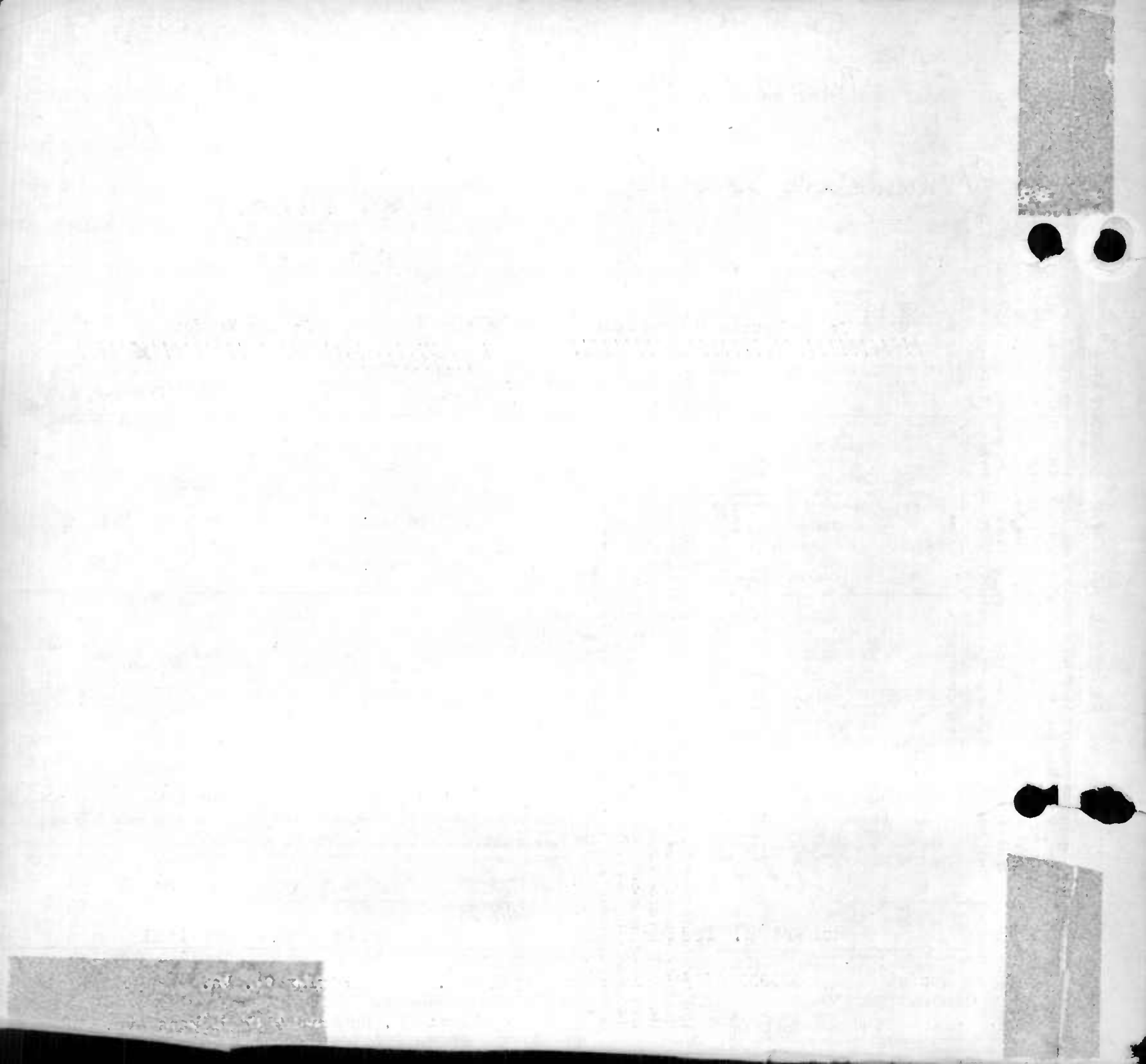


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the funeral home. Also, if the direct or contributing cause of death was a homicide, the body must be released to the medical examiner. Shows: (1) An accident of nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6001				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 6001	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Thompson Maudie E.		2. DATE AND HOUR OF DEATH 5 June 65 12 ⁰⁵ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 99		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Edgewater			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Montebello State Hospital				D. STREET ADDRESS (If rural, give location) Rt #4 Box #1					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 4/19/1900	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME James Morris Thompson				14. MOTHER'S MAIDEN NAME Jannie Walford					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Virginia Miles 501 Morning Side Drive			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) cardiac arrest DUE TO (B) broncho pneumonia DUE TO (C) carcinomatosis				INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5/11/65 to 6/5/65, that (I) (we) last saw the deceased alive on 6/5/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Robert W. Ireland M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/5/65			
23C. PHYSICIAN'S NAME (Type) Robert W. Ireland M.D.				23D. ADDRESS Montebello State Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/8/65		24C. NAME of CEMETERY or CREMATORY Andrews Chapel Cem.		24D. LOCATION (City, town, or county) (State) Fairfax Co. Va.			
25A. DATE REC'D BY HEALTH DEPT. JUN 8 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens					



FUNERAL DIRECTOR: IMPORTANT

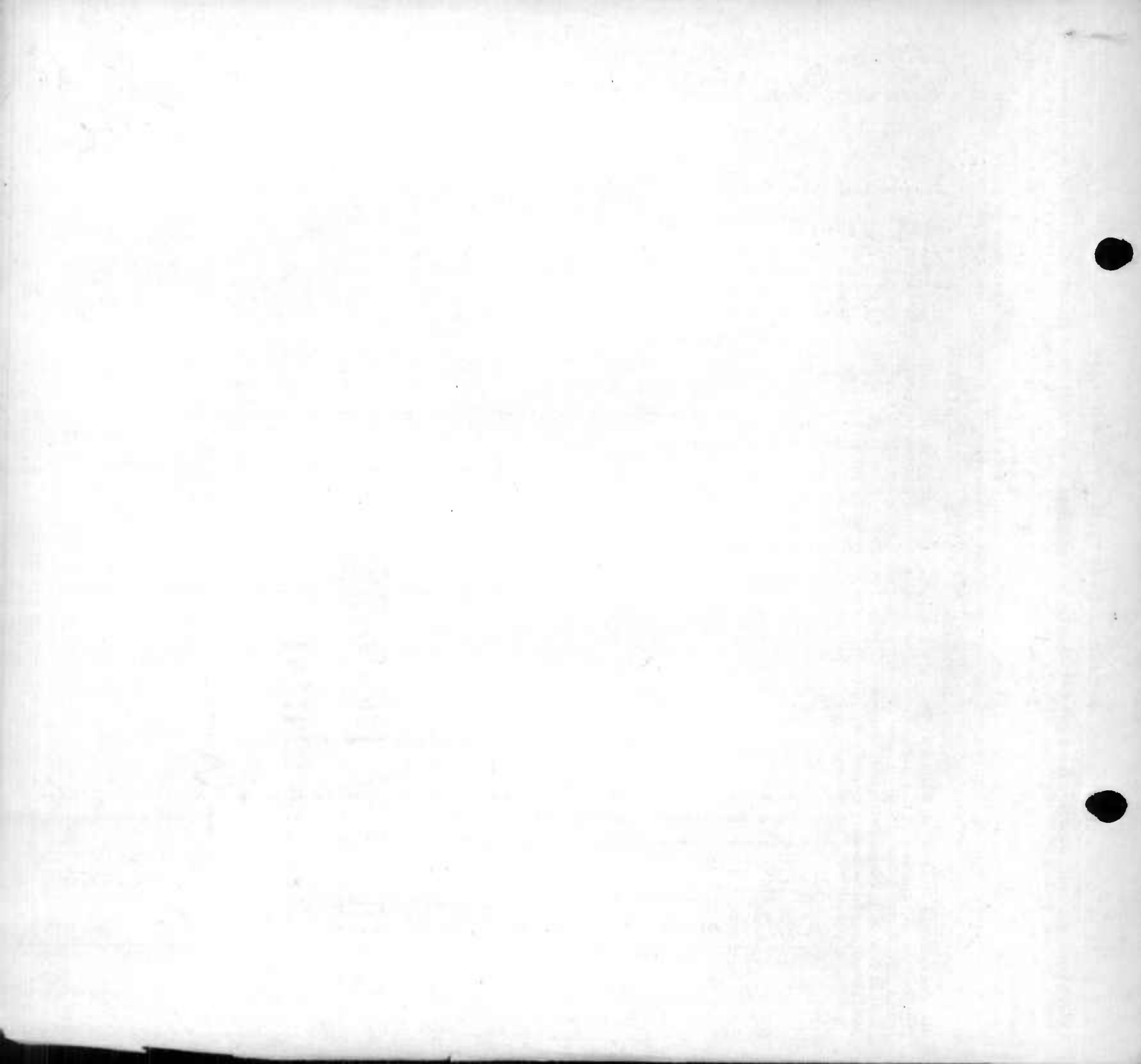
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6002	
BIRTH NO. 65 6002		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Lloyd Lounge Lawrence</i>		2. DATE AND HOUR OF DEATH <i>6-5-65 4:50 p.m.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>AA</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Severn</i>			
		D. STREET ADDRESS (If rural, give location) <i>Route 3 Box 3</i>			
5. SEX <i>m</i>	6. RACE <i>w</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>m</i>	8. DATE OF BIRTH <i>2-12-1896</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Social Security</i>		11. BIRTHPLACE (State or foreign country) <i>md</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Francis Lawrence</i>		14. MOTHER'S MAIDEN NAME <i>Anne Appleby</i>		ADDRESS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes WW I</i>		16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>Hospital Record</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cardiac arrest</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <i>acute coronary occlusion</i>			
		(B) DUE TO <i>ASCVD - PVD</i>			
		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-5-1965</i> to <i>6-5-1965</i> , that (I) (we) last saw the deceased alive on <i>6-5-1965</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Masao Maeshiro</i>		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6-5-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>MASAO MAESHIRO</i>		23D. ADDRESS <i>University Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-8-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 8 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR <i>Arthur H. Haight, Sykesville, Md.</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6003		CERTIFICATE OF DEATH		Registered No. 65 6003	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Brockington Julia		2. DATE AND HOUR OF DEATH 6-5-65 9 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 15-01		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran hospital of M.D.		D. STREET ADDRESS (If rural, give location) 1647 W. North Ave.			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-14-22	9. AGE (In years last birthday) 42	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	12. CITIZEN OF WHAT COUNTRY? O.S.A.
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Jane Davis		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Glascia Brockington		ADDRESS 1647 W. North Ave.	
18. 587.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Ante hemorrhagic pancreatitis		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-1-1965 to 6-5-1965 , that (I) (we) last saw the deceased alive on 6-5-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G.H. Achib M.D.				23B. DATE SIGNED 6-5-65	
23C. PHYSICIAN'S NAME (Type) CHASSEM. POWR M.D.		23D. ADDRESS Lutheran hospital of M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/9/65	24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Ch. Baltimore		24D. LOCATION (City, town, or county) (State) M.D.	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Fairley M.D.		25C. FUNERAL DIRECTOR Ushington S. Phillips	
				ADDRESS 1727 N. Monmouth	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6004		BALTIMORE DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 6004	
1. NAME OF DECEASED (Type or Print) BERGLOWE, SOPRIN			2. DATE AND HOUR OF DEATH 6/6/65 7:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 9-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 601 E 30th St		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9/1/1890	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Oslo, Norway		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ANDERS TAKALUSEN		14. MOTHER'S MAIDEN NAME ELSIE MARIE KITTELSEN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Balto., Md. 21208		18. MOTHER'S MAIDEN NAME Mrs. Mildred Nicholson, 3715 Evergreen Ave	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) MI ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASC CD Benign Hypertension Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH Sudden		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5/25/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastric Tumor		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/16 19 65 to 6/6 19 65 , that (I) (we) last saw the deceased alive on 6/6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Arturo Novico				23B. DATE SIGNED 6/6/65	
23C. PHYSICIAN'S NAME (Type) ARTURO NOVICO		23D. ADDRESS MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE June 9, 65		24C. NAME OF CEMETERY or CREMATORY Lorraine Pk.	
24D. LOCATION (City, town, or county) (State) Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Loring Byers, 8728 Liberty Rd., Randallstown			

PORT HEALTH DEPT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 6005 CERTIFICATE OF DEATH					Registered No. 65 6005				
BIRTH NO.					2. DATE AND HOUR OF DEATH				
M.E. CASE NO.					6. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print)					CLIFFORD EDWARD RINGGOLD JUNE 5, 1965 6:20 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
OF FRANKLIN SQUARE					MD USA Baltimore				
5. SEX					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
M W					Pikesville, MD 5300				
6. RACE					D. STREET ADDRESS (If rural, give location)				
W					12 SALEM COURT				
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)					B. DATE OF BIRTH				
married					3/13/94				
8. DATE OF BIRTH					9. AGE (In years last birthday)				
3/13/94					68				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					11. BIRTHPLACE (State or foreign country)				
FOREMAN SHEET METAL					MARYLAND				
13. FATHER'S NAME					12. CITIZEN OF WHAT COUNTRY?				
JAMES ROLR RINGGOLD					USA				
14. MOTHER'S MAIDEN NAME					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
MARY WHALAND					no				
16. SOCIAL SECURITY NO.					17. INFORMANT				
216-01-3056					Mrs Grace C. Ringgold				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					ADDRESS				
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					12 Salem Court Pikesville Md				
ANTECEDENT CAUSES					INTERVAL BETWEEN ONSET AND DEATH				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					6 hours				
II					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
2					yes				
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
yes									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED				
					While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from					JUNE 5, 1965 to				
that (I) (we) lost saw the deceased alive on					JUNE 5, 1965 and that in (my) (our) opinion death occurred on the date				
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
PE BRION					6/5/65				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
PE BRION					FRANKLIN SQ. 1105P.				
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE				
Burial					6-9-65				
24C. NAME OF CEMETERY or CREMATORY					24D. LOCATION (City, town, or county) (State)				
Druid Ridge					Pikesville Md				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR				
JUN 9 1965					Robert E. Fisher				
25C. FUNERAL DIRECTOR					ADDRESS				
Loring Byrnes					8720 Liberty Rd				

7.1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				DEATH DEPARTMENT				Registered No.			
M.E. CASE NO.				1. NAME OF DECEASED				2. DATE AND HOUR OF DEATH			
(Type or Print)				JOHN IE MILLER				JUNE 5 - 1965 11:40A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY							
702 S. FREMONT AVE				MD BALTIMORE							
5. SEX				6. RACE				7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)			
M				N							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
GRAIN TRIMMER				PORT J BALTIMORE				JACKSON CO. FLA.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
CHARLIE MILLER				NANCY FEENER				USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
NO				264.05-6021				CELESTINE MILLER 702 S. FREMONT AVE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO				ON KNOWN			
ANTECEDENT CAUSES				(B) DUE TO							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,				(C) DUE TO							
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
								NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JAN 1, 1962 to JUNE 5, 1965, that (I) (we) lost saw the deceased alive on JUNE 4, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
JOHN S. BRAXTON JR.				JUNE 8, 1965							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
JOHN S. BRAXTON JR.				922 S. SHARP BALT. 30, MD							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY or CREMATORY			
REMOVAL				6/10/65				SHILOH BAPT.			
24D. LOCATION (City, town, or county) (State)				25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
GREENVILLE Florida				JUN 9 1965				Robert E. Faulkner			
25C. FUNERAL DIRECTOR ADDRESS				25D. NAME OF REGISTRAR				25E. FUNERAL DIRECTOR ADDRESS			
Margaret R. Hays 638 N. G. Street											

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 6007	
BIRTH NO.		65 6007		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ARTHUR W. BRENT		2. DATE AND HOUR OF DEATH 6-7-1965 1 3P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY 23-01			
FULL NAME OF HOSPITAL OR INSTITUTION 934 LEADENHALL ST		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 934 LEADENHALL ST			
5. SEX M	6. RACE COI	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-4-1898	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY WEST. MD RR. Co.		11. BIRTHPLACE (State or foreign country) CHARLES Co. MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN W. BRENT		14. MOTHER'S MAIDEN NAME ELIZABETH THOMAS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-09-6717		17. INFORMANT JOSEPHINE BRENT - same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma right lung		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6/5		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/5 6/5 19 65 to 6/7 19 65 , that (I) last saw the deceased alive on 6/5 6/5 19 65 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE John P. Urlock Jr.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/8/65	
23C. PHYSICIAN'S NAME (Type) JOHN P. URLOCK JR		23D. ADDRESS 1227 Wash. Blvd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burned		24B. DATE 6/12/65		24C. NAME OF CEMETERY or CREMATORY Not known	
24D. LOCATION (City, town, or county) (State) Baltimore					
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Marshall P. Hayes	
ADDRESS 638 N. GILMORE ST					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6008				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6008			
M.E. CASE NO.				1. NAME OF DECEASED				2. DATE AND HOUR OF DEATH			
(Type or Print)				AGNES F. DUNNE				JUNE 7, 1965 6:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				MARYLAND				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
ST AGNES HOSPITAL				BALTIMORE				D. STREET ADDRESS (If rural, give location)			
				6 N. WOODINGTON RD.				28-04			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY?	
FEMALE		WHITE		NEVER MARRIED		2-24-75		90		U S	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
MILLINER-RET.				SHOP				CINCINNATI OHIO			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
DUNNE				MARGARET DUNNE				No			
16. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
49-07-8595				ST AGNES HOSPITAL WILKENS AND CATON				AVE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) Bronchopneumonia							
ANTECEDENT CAUSES				(B) Adenocarcinoma, Colon							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)							
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
D								No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from APRIL 28 1965 to JUNE 7 1965, that (I) (we) last saw the deceased alive on JUNE 7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE								23B. DATE SIGNED			
Carmen Fratto								6/7/65			
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS			
CARMAN FRATTO								1000 S. Caton Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
Burial				6-8-65		St. Margarets Cemetery				Montgomery Alabama	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR			
JUN 9 1965				R. E. Farber M.D.				John J. Farber (Farber & Co)			

STATE OF NEW YORK

IN SENATE

JANUARY 12, 1917

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

ALBANY

LS: 43-76-77

B-463

FUNERAL DIRECTOR: IMPORTANT

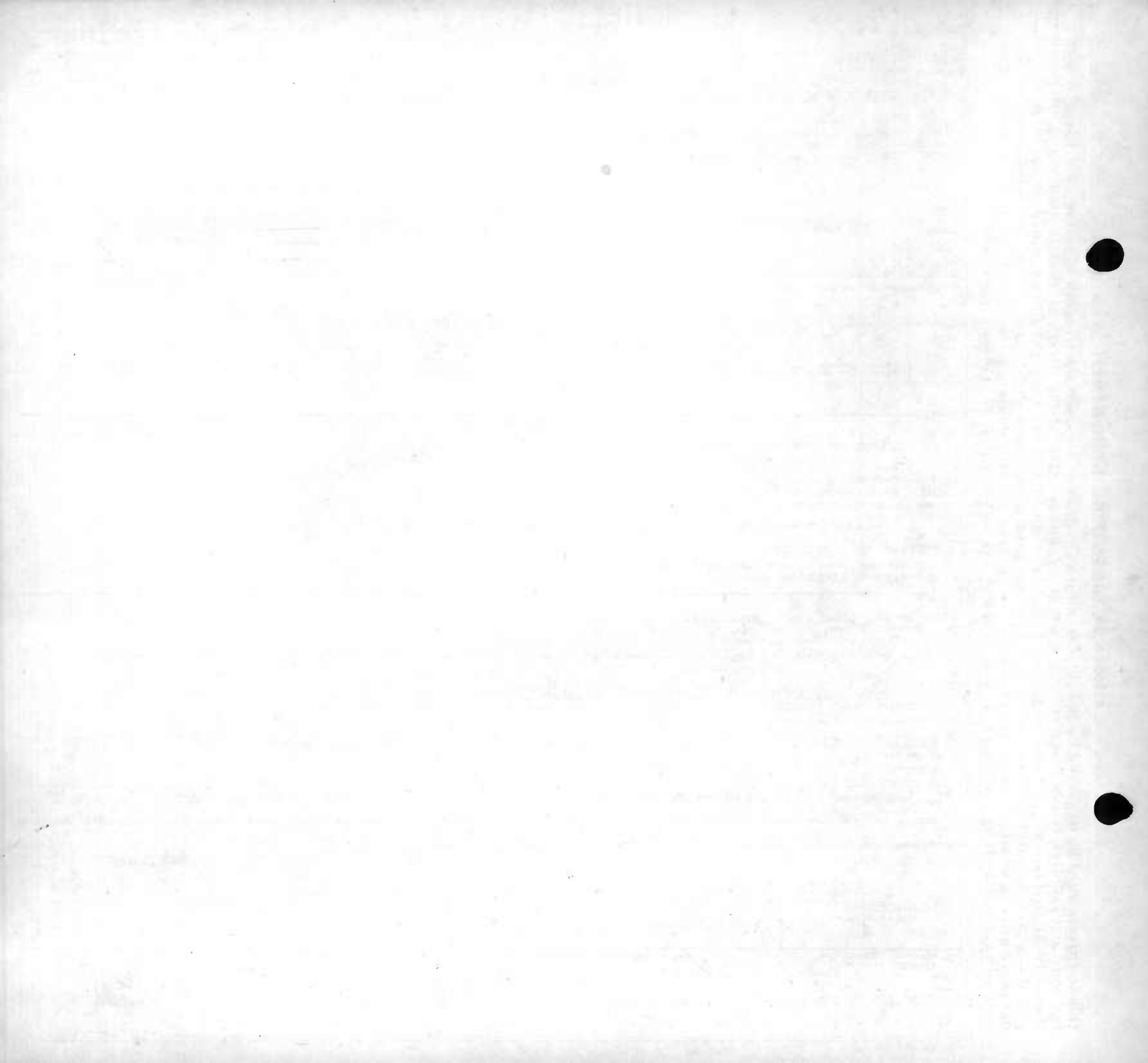
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6009				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6009	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Louis Bullard				2. DATE AND HOUR OF DEATH June 5, 1965		8:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3209 N. Charles Street #21218			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5-20-85	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Chiropractor		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-38-411		17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 331XY 260X Cerebral Vascular Accident DUE TO				INTERVAL BETWEEN ONSET AND DEATH 2 Days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Operative Hypoxia DUE TO				2 Days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitis Cholechoolithiasis				1 Week			
19A. DATE OF OPERATION 6-3-1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholechoolithiasis		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 3, 19 65 to June 5, 19 65, that (I) (we) last saw the deceased alive on June 5, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Donald M. Baltzan				23B. DATE SIGNED June 5, 1965		23C. PHYSICIAN'S NAME (Type) Dr. Donald M. Baltzan	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/10/65		24C. NAME of CEMETERY or CREMATORY Moreland Memorial		24D. LOCATION (City, town, or county) (State) Taylor Ave. Baltimore	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Co. 108 W North Av. City			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>65-14229</u>		65 6010		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 6010</u>	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH <u>6/5/65</u> <u>8:45</u> P.M.			
1. NAME OF DECEASED (Type or Print) <u>Baby Van Lill</u>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>Bon Secours Hospital</u> (If not in hospital or institution, give street address or location)			
FULL NAME OF HOSPITAL OR INSTITUTION				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>28-84</u> B. COUNTY			
5. SEX <u>Female</u>				6. RACE <u>White</u>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH <u>6-5-65</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Edgar J. Van Lill</u>				14. MOTHER'S MAIDEN NAME <u>Edna I. Parker</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give year or dates of service				16. SOCIAL SECURITY NO.			
17. INFORMANT				ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Atelectasis</u> (A) DUE TO <u>Prematurity</u> (B) DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				II			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6/5/65</u> 19 to <u>6/5/65</u> 19, that (I) (we) last saw the deceased alive on <u>6/5/65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Edward L. Frey</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>6/5/65</u>			
23C. PHYSICIAN'S NAME (Type) <u>EDWARD L. FREY</u> M.D.				23D. ADDRESS <u>4605 Edmondson Ave 21329</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>6-9-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Mem Park</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 9 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>Therese J. Pink</u>		ADDRESS <u>Glen Burnie Md</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6011				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6011	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Smith Sophie</i>		2. DATE AND HOUR OF DEATH <i>6-4-65</i> <i>IP.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Lutheran Hospital of Maryland</i>				A. STATE <i>Maryland</i> B. COUNTY <i>Anne Arundel</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Glen Burnie</i> <i>5200</i>			
				D. STREET ADDRESS (If rural, give location) <i>Glen Burnie, Md. 7374 FURNACE BRANCH</i>			
5. SEX <i>female</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>8-25-1922</i>		9. AGE (in years last birthday) <i>42</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Presser (ret.)</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Uniform Mfg. Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Ratajzak</i>				14. MOTHER'S MAIDEN NAME <i>Mary (unknown)</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>212 07 2749</i>		17. INFORMANT ADDRESS <i>Mrs. Lula Stewart Same As #2</i>			
18. <i>260X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Acute pulmonary edema</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>secondary to high blood pressure</i> <i>ad. pneumonia</i> <i>diabetes</i>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6-4-1965</i> to <i>6-4-1965</i> , that (I) (we) lost saw the deceased alive on <i>6-4-1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>CHASSEM</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6-4-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>CHASSEM POUR HAIB</i>				23D. ADDRESS <i>Lutheran Hosp. of Maryland</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>June 11/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Carmel Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Singleton</i>		25C. FUNERAL DIRECTOR <i>R.V. Singleton, Glen Burnie, Maryland</i>		ADDRESS	

1914

Letter of 1914

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Letter of 1914

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Letter of 1914

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Letter of 1914

BIRTH NO.

65 6012

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

VII.

ISAAC NICHOLSON

2. DATE AND HOUR PRONOUNCED DEAD

6-7-65

4:08 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

WORCESTER

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Berlin

D. STREET ADDRESS (If rural, give location)

Box 141

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

Aug. 2, 1910

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MERCHANT, RETAIL

10B. KIND OF BUSINESS OR INDUSTRY

RESTAURANT
RETAIL BUS

11. BIRTHPLACE (State or foreign country)

Accomac County VA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

ERNEST NICHOLSON

14. MOTHER'S MAIDEN NAME

ELIZA LANKI

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

World War II 216-09-9310

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. I. W. Nicholson

Berlin MD

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) ~~XXXX~~

Multiple traumatic injuries

with craniocerebral injury

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) ~~XXXX~~

DUE TO

(C) ~~XXXX~~

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Airport

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)North Ramp at Butler Aviation
Friendship Airport, Inc.21D. TIME
OF INJURY
(APPROX.)

6

6

'65

(Hour)
7:30
PM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR? Walked into moving

airplane propeller

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

6-7-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL 6/10/65

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

EVERGREEN

23D. LOCATION

(City, town, or county)

BERLIN

MD

24A. DATE REC'D BY HEALTH DEPT.

JUN 9 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Anna A. Barbours Berlin Md.

WALLEY FORD

NOV 1910

MADE IN U.S.A.

MADE IN U.S.A.

MADE IN U.S.A.

MADE IN U.S.A.

MADE IN U.S.A.

MADE IN U.S.A.

MADE IN U.S.A.

MADE IN U.S.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-14037		65 6013		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6013	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Baby Girl GERHARDT				2. DATE AND HOUR OF DEATH 6/7/65 7:50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY Balto	
H. A. Therman Hospital of Maryland				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		5370	
				D. STREET ADDRESS (If rural, give location) 219 S. MARLYN AVE.		2122	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married	8. DATE OF BIRTH 6/5/65	9. AGE (In years last birthday) 2	10. If Under 1 Yr. Months 1	11. If Under 24 Hrs. Hours 26	12. If Under 24 Hrs. Min. 26
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John H. Gebhardt				14. MOTHER'S MAIDEN NAME MICHELLE MALSTROM			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Father (Same as above)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury at complication which caused death.)				(A) DUE TO Respiratory distress syndrome			
ANTECEDENT CAUSES				(B) DUE TO prematurity			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) prematurity rupture membrane			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 6/5 to 6/7/65, that (I) (we) last saw the deceased alive on 6/7/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Hossein Golpira				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/7/65	
23C. PHYSICIAN'S NAME (Type) Hossein Golpira				M.D.		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/8/65		24C. NAME OF CEMETERY or CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) Balto. Co. Md.	
25A. DATE REC'D BY HEALTH/DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR		ADDRESS Connelly 300 Mace Ave, 21	

100-1000
100-1000
219-219000

100-1000
100-1000

100-1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

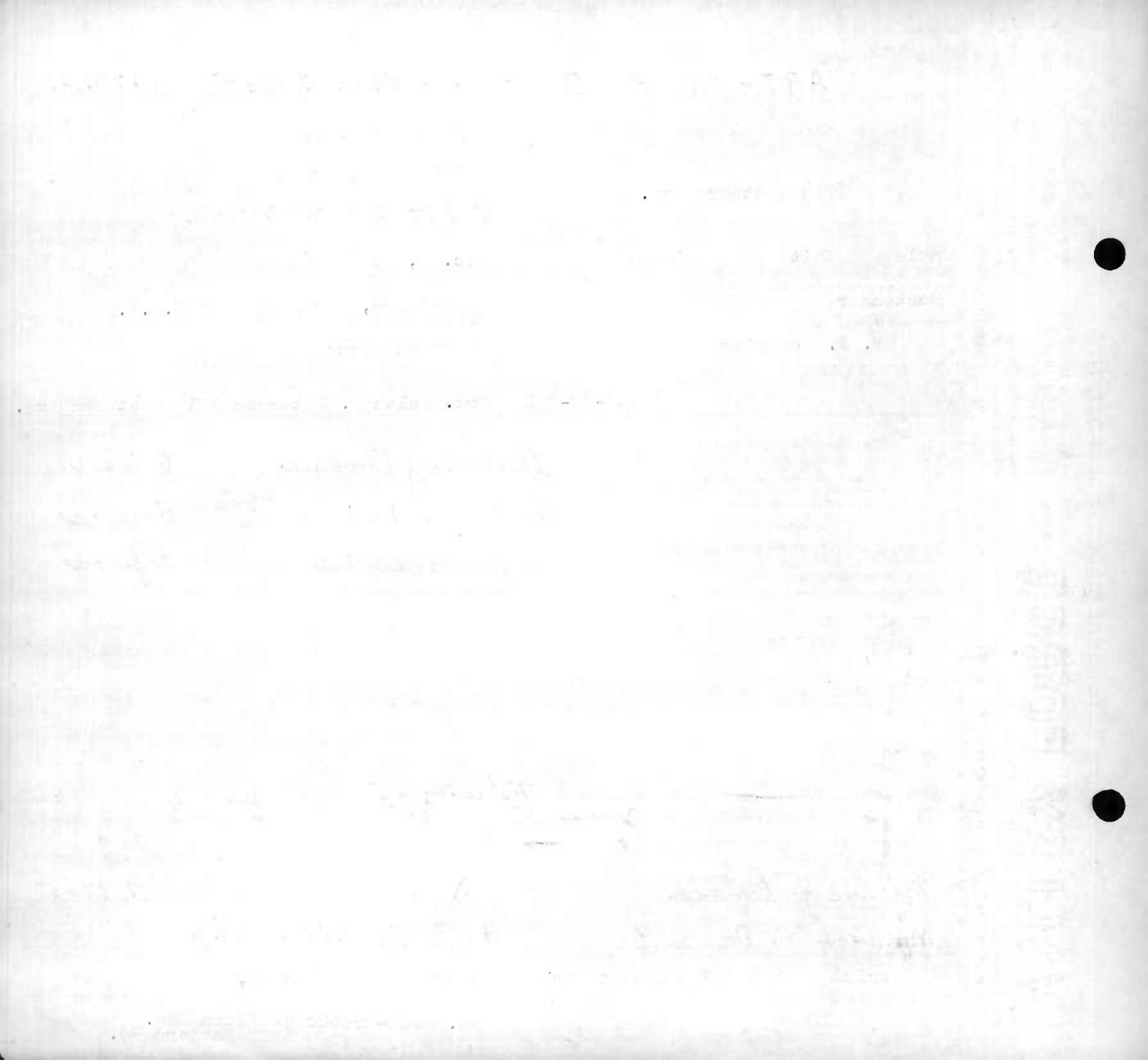
BALTIMORE CITY HEALTH DEPARTMENT									
65 6014					Registered No. 65 6014				
BIRTH NO.									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) JOSEPHINE SMERDZINSKI					2. DATE AND HOUR OF DEATH JUNE 4, 1965 2:40 P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)			A. STATE MARYLAND		B. COUNTY 1-03		
616 S. PORT ST.					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
					D. STREET ADDRESS (If rural, give location) 616 S. PORT ST.				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 3-17-1895	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 215-05-7280		17. INFORMANT FELIX SMERDZINSKI		ADDRESS 2430 FAIT AVE.		
18. 191.5 I					CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)					(A) Generalized Metastasis DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) Malignant Melanoma of Mid-Back DUE TO				
					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -----		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 26 1964 to June 4 1965 , that (I) (we) last saw the deceased alive on June 4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Joseph F. Drenga					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 7, 1965		
23C. PHYSICIAN'S NAME (Type) Joseph F. Drenga					23D. ADDRESS 209 S. Chester Str; Baltimore, Md. 21231				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-8-1965		24C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE MD.			
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI		ADDRESS 2525 FLEET ST.			

John F. Murphy

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT					Registered No. 65 6015	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		65 6015 ARTHUR H. DEEHRING			2. DATE AND HOUR OF DEATH June 7, 1965 12:30 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3714 Southern Ave.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
				D. STREET ADDRESS (If rural, give location) 3714 SOUTHERN-AVE.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Dec. 3, 1895	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Wm. F. Deehring			14. MOTHER'S MAIDEN NAME Susan Spuck			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-07-9518		17. INFORMANT Mrs. Helen D. Peterson 3714 Southern Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Pulmonary Edema (B) Cardio-Vascular Hypertensive Disease (C) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 hours 5 years 5 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from February 25, 1965 to June 7, 1965, that (I) lost saw the deceased alive on June 5, 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.						
23A. SIGNATURE Michael J. Dausch				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 7, 1965
23C. PHYSICIAN'S NAME (Type) Michael J. DAUSCH				23D. ADDRESS M.D. 4636 BELAIR-ROAD		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/10/65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Hamilton Inc. 6009 Harford Rd.		



65 6016

BALTIMORE CITY HEALTH DEPARTMENT

65 6016

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

CARL TAYLOR

2. DATE AND HOUR PRONOUNCED DEAD

June 5, 1965

6:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1700 N. Calvert Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

March 27, 1904

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Mount Airy, N. Car.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Silas Taylor

14. MOTHER'S MAIDEN NAME

Kizzie Simmons

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

259-05-5452

17. INFORMANT

Mrs. Elsie J. Taylor

ADDRESS

1700 N. Calvert St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-5-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

June 8, 65

23C. NAME of CEMETERY or CREMATORY

St. Paul's Fifth Reformed

23D. LOCATION

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUN 9 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Wm. Cook-Brooks, Inc. 1217 St. Paul St.

ADDRESS

VALLEY FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6017	
BIRTH NO. M.E. CASE NO.		65 6017		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MAGLIDT, WILLIAM H.		6/1/65		9:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MD.		A. STATE: MARYLAND. B. COUNTY: Baltimore.			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ORCHARD BEACH			
		D. STREET ADDRESS (If rural, give location) 7930 MAIN ST. 62-00			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 1/23/1874	9. AGE (In years last birthday) 91	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED.		10B. KIND OF BUSINESS OR INDUSTRY Gardner		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William A. Maglidt		14. MOTHER'S MAIDEN NAME Elmira Maglidt (?)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-05-0407		17. INFORMANT Family records	
18. 782.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) UREMIA. DUE TO (B) CARDIAC FAILURE. DUE TO (C) SENILITY.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/22 1965 to 6/1 1965, that (I) (we) last saw the deceased alive on 6/1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joon Sueck Lee				23B. DATE SIGNED 6/1/65	
23C. PHYSICIAN'S NAME (Type) JOON SUECK LEE		23D. ADDRESS LUTHERAN HOSPITAL OF MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 4, 1965		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	
				24D. LOCATION (City, town, or county) (State) Parkville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland	

FUNERAL DIRECTOR: IMPORTANT

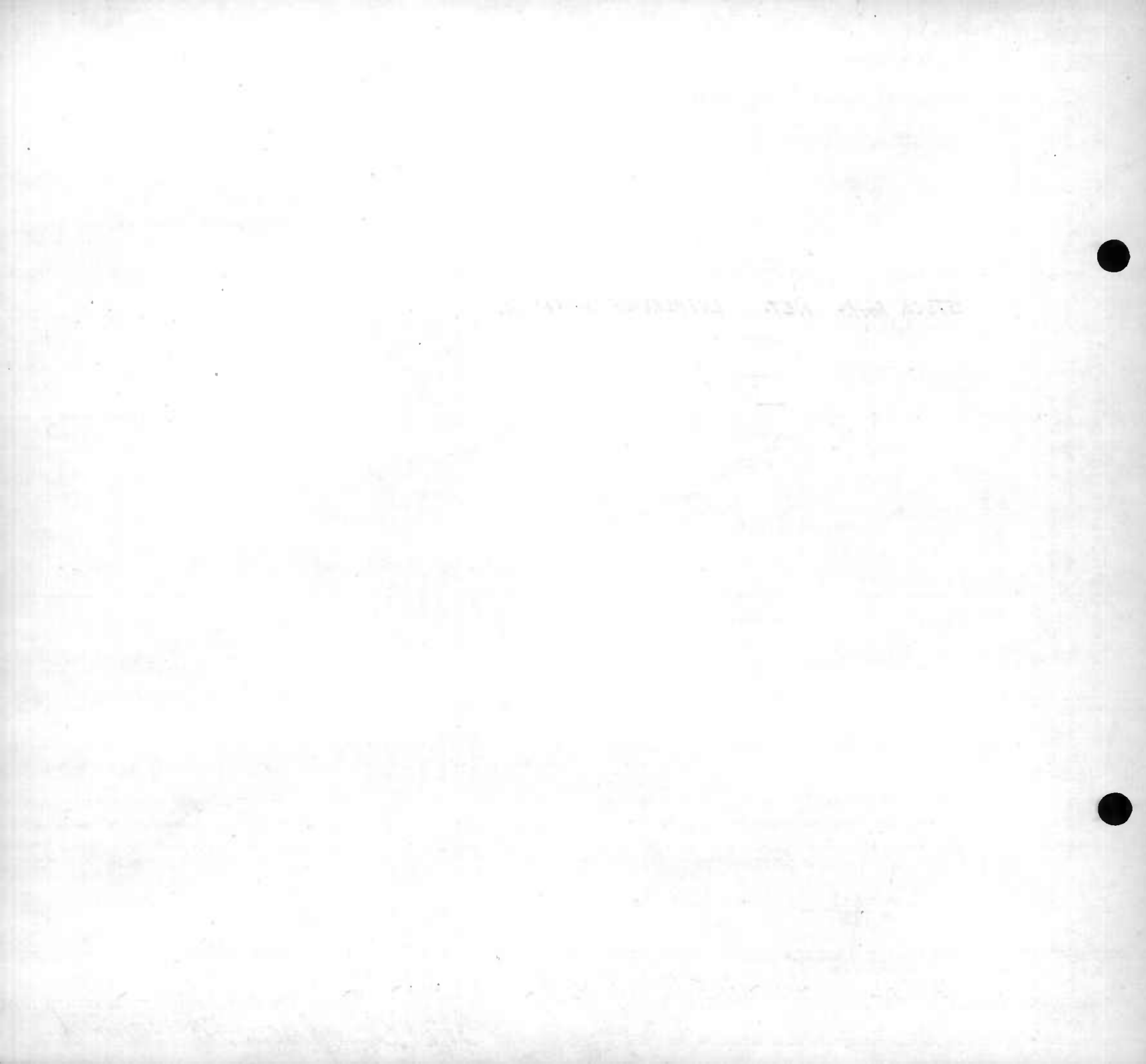
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6018	
BIRTH NO. 65 6018		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Mary Elizabeth Wilson</u>		2. DATE AND HOUR OF DEATH <u>6.2.65</u> <u>1:30</u> <u>PM</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Cockeysville</u> <u>03-00</u>			
		D. STREET ADDRESS (If rural, give location) <u>Box 39</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>8.23.98</u>	9. AGE (In years lost birthday) <u>66</u>	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland, Baltimore County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Perry</u>		14. MOTHER'S MAIDEN NAME <u>Dora Greene</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-1358</u>	17. INFORMANT <u>Alice Cummings</u> ADDRESS <u>Morton, Md.</u>		
18. <u>502.01</u>		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) <u>Acute Pulmonary Edema</u>			<u>30 min.</u>
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(B) <u>CO2 Narcosis</u>			<u>48 hours</u>
ANTECEDENT CAUSES		(C) <u>Chronic Bronchitis + Emphysema</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6.1</u> 19 <u>65</u> to <u>6.2</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>6.2</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>D. Lindenstruth</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>6-2-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>D. Lindenstruth</u>				23D. ADDRESS <u>M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>JUN. 5 1965</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Jessop's Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Cockeysville, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 9 1965</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	25C. FUNERAL DIRECTOR ADDRESS <u>John Burns' Sons, Towson, Md.</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 6019	
BIRTH NO. 65 6019		CERTIFICATE OF DEATH								Registered No. 65 6019	
1. NAME OF DECEASED (Type or Print) Donald Gillispie						2. DATE AND HOUR OF DEATH June 4, 1965 3:30 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Towson, Md. 63-00 D. STREET ADDRESS (If rural, give location) 200 Donnybrook Lane					
5. SEX m		6. RACE cauc		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) sep.		8. DATE OF BIRTH 1-14-38		9. AGE (In years last birthday) 27		10. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOCK MGR- RET.						10B. KIND OF BUSINESS OR INDUSTRY LUTHERVILLE SUPPLY CO. Md.					
13. FATHER'S NAME Jacob Gillispie						14. MOTHER'S MAIDEN NAME Blanche Boone					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Acc Rm sheet ADDRESS					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 260X1 bilateral lower lobe pneumonia with anoxia and cardiac arrest.										INTERVAL BETWEEN ONSET AND DEATH ? week	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, diabetes mellitus										24 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. hypophysectomy for retinitis proliferans neuropathy, nephropathy,										??	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6-3-1965 to 6-4-1965, that (I) (we) last saw the deceased alive on 6-4-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Joseph H. Marr								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-4-65	
23C. PHYSICIAN'S NAME (Type) J. Joseph Marr						23D. ADDRESS M.D. Johns Hopkins Hospital					
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JUN. 7, 1965		24C. NAME of CEMETERY or CREMATORY Dulaney Valley Memorial				24D. LOCATION (City, town, or county) (State) Cockeysville, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR John Burns' Sons				ADDRESS Towson, Md.			

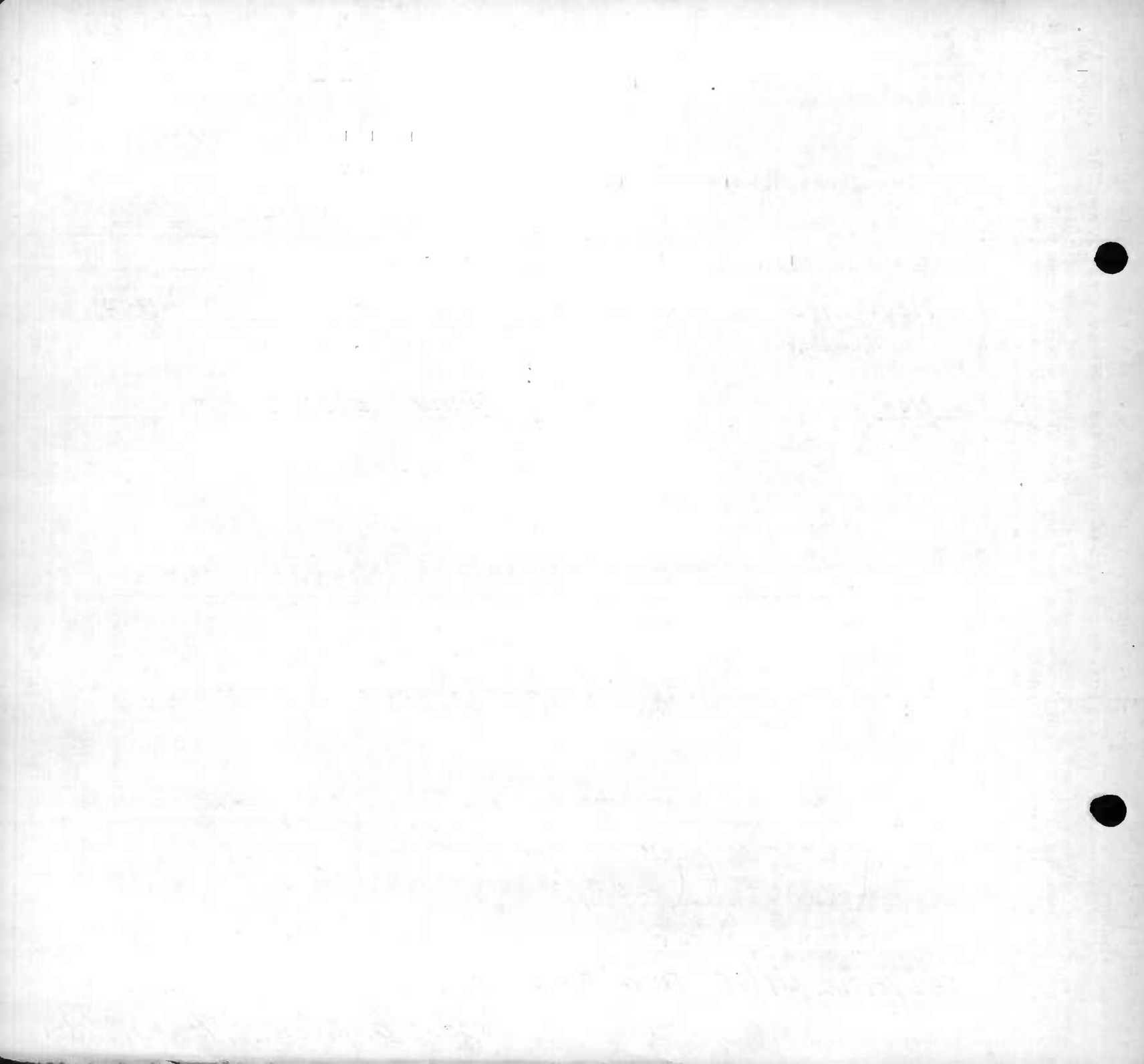


6-6-65. THE BODY OF MARY J. HARRISON HAS BEEN RELEASED BY DR. ADAMS OF THE MEDICAL OFFICE. NON MED. P.D. Party APPROVAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6020				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6020	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MARY J. HARRISON				2. DATE AND HOUR OF DEATH 6-5-65 11:55 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				A. STATE VIRGINIA		B. COUNTY 11-43	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) WAVERLY			
				D. STREET ADDRESS (If rural, give location) RURAL			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW		8. DATE OF BIRTH 6-27-84	
9. AGE (In years lost birthday) 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN BAGE				14. MOTHER'S MAIDEN NAME MARY V. CHARLES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT FAMILY RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Abdominal Sepsis (B) Total Bowel Infarction (C) Mesenteric Artery Thrombosis		INTERVAL BETWEEN ONSET AND DEATH several hours	
19. DATE OF OPERATION 6.5.65				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal Sepsis		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 6.5.1965 to 6.5.1965, that (we) last saw the deceased alive on 6.5.1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.							
23A. SIGNATURE Hormoz Azar M.D.				23B. DATE SIGNED 6.5.65			
23C. PHYSICIAN'S NAME (Type) Hormoz Azar M.D.				23D. ADDRESS Johns Hopkins Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) REM./BURIAL		24B. DATE 6/8/65		24C. NAME OF CEMETERY or CREMATORY FAMILY BURIAL GROUND		24D. LOCATION (City, town, or county) (State) WAVERLY, VIRGINIA	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965				25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS John Burns' Sons, Towson, Md.	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 6021		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6021	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Crabbe, Louis			June 6, 1965 9:20 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital Inc.			A. STATE Maryland B. COUNTY 16-07		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 1200 Ashburton Street		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5-3-01	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James Crabbe		14. MOTHER'S MAIDEN NAME Virginia Wilson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT LENG Crabbe 1200 Ashburton St	
18. 444X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Ozobemia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Ozobemia DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 29, 1965 to June 6, 1965 , that (I) (we) last saw the deceased alive on June 5, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Roger Theodore			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) Dr. Roger Theodore			23D. ADDRESS M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-10-65		24C. NAME of CEMETERY or CREMATORY Zion Cem.	
24D. LOCATION (City, town, or county) (State) Tucker Hill, Va		25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. ...	
25C. FUNERAL DIRECTOR George A. Kula		25D. ADDRESS 1348 N. Carbon St			

8/65 - Generalized Arteriosclerosis
Essential Hypertension
Inform from President Hosp - see Doc't file
Bur. of Biostatistics - American Bldg - K.

FUNERAL DIRECTOR: IMPORTANT

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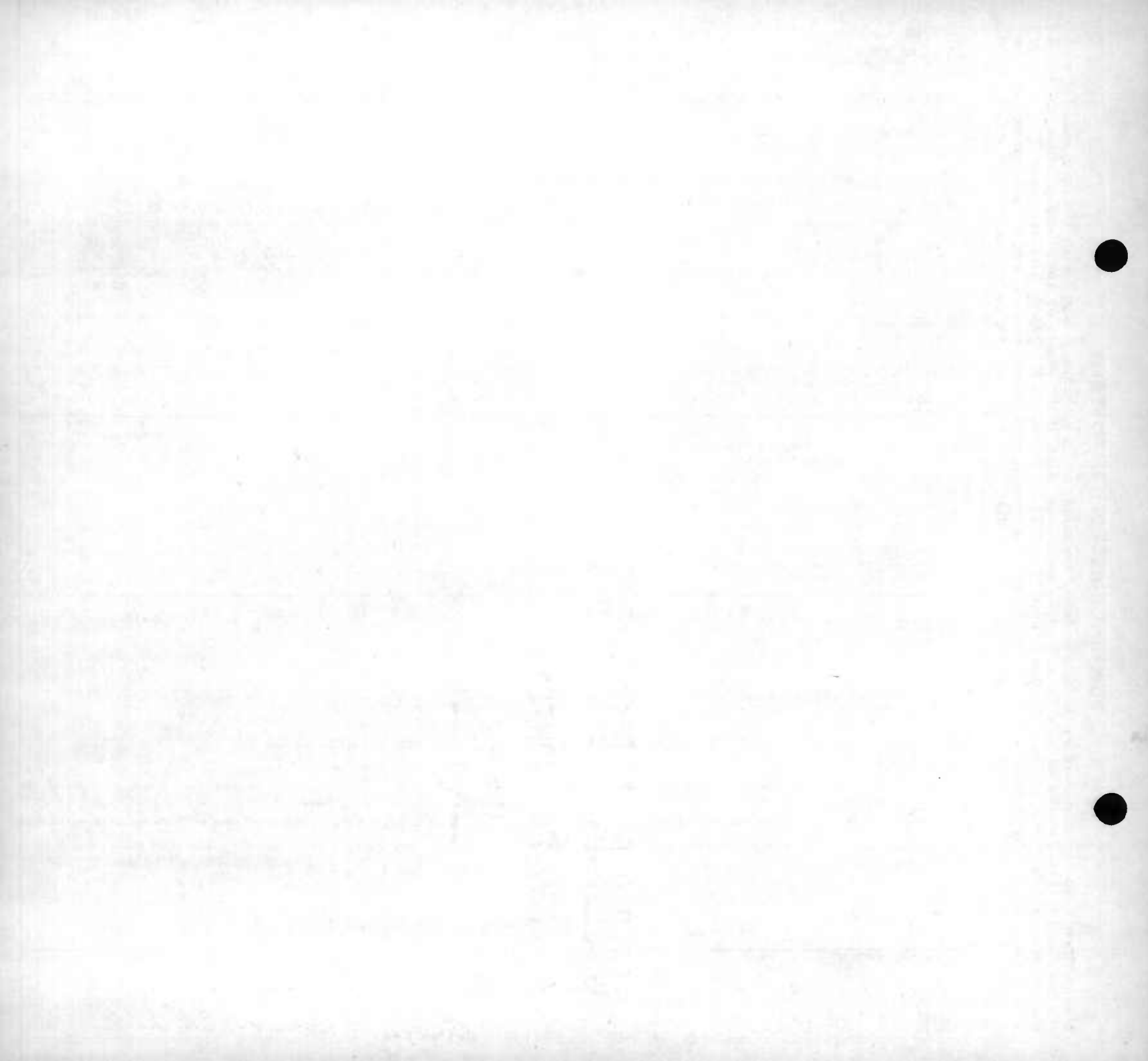
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 6022		CERTIFICATE OF DEATH		65 6022	
1. NAME OF DECEASED (Type or Print) <i>Harry W White</i>			2. DATE AND HOUR OF DEATH <i>VI-6-65 6:40 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>13-02</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
			D. STREET ADDRESS (If rural, give location) <i>825 Lexington Ave.</i>		
5. SEX <i>M</i>	6. RACE <i>E</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>VI-4-04</i>	9. AGE (In years lost birthday) <i>61</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>construction</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Howard Co Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Henry White</i>			14. MOTHER'S MAIDEN NAME <i>Marial</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-14-0088</i>	17. INFORMANT ADDRESS <i>Wife - 8109 Smallwood St</i>		
18. <i>332X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO <i>Hemorrhagic infarction at the base</i> (B) DUE TO <i>Hypertension</i> (C)		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>VI-2 1965</i> to <i>VI-6 1965</i> , that (I) (we) last saw the deceased alive on <i>VI-6 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Rodrigo Toro</i>			23B. DATE SIGNED <i>VI-6-65</i>		
23C. PHYSICIAN'S NAME (Type) <i>Rodrigo Toro</i>			23D. ADDRESS <i>University Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>6-9-65</i>	24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Talley</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Stacy H. Hilly 1548 N. Calhoun St</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

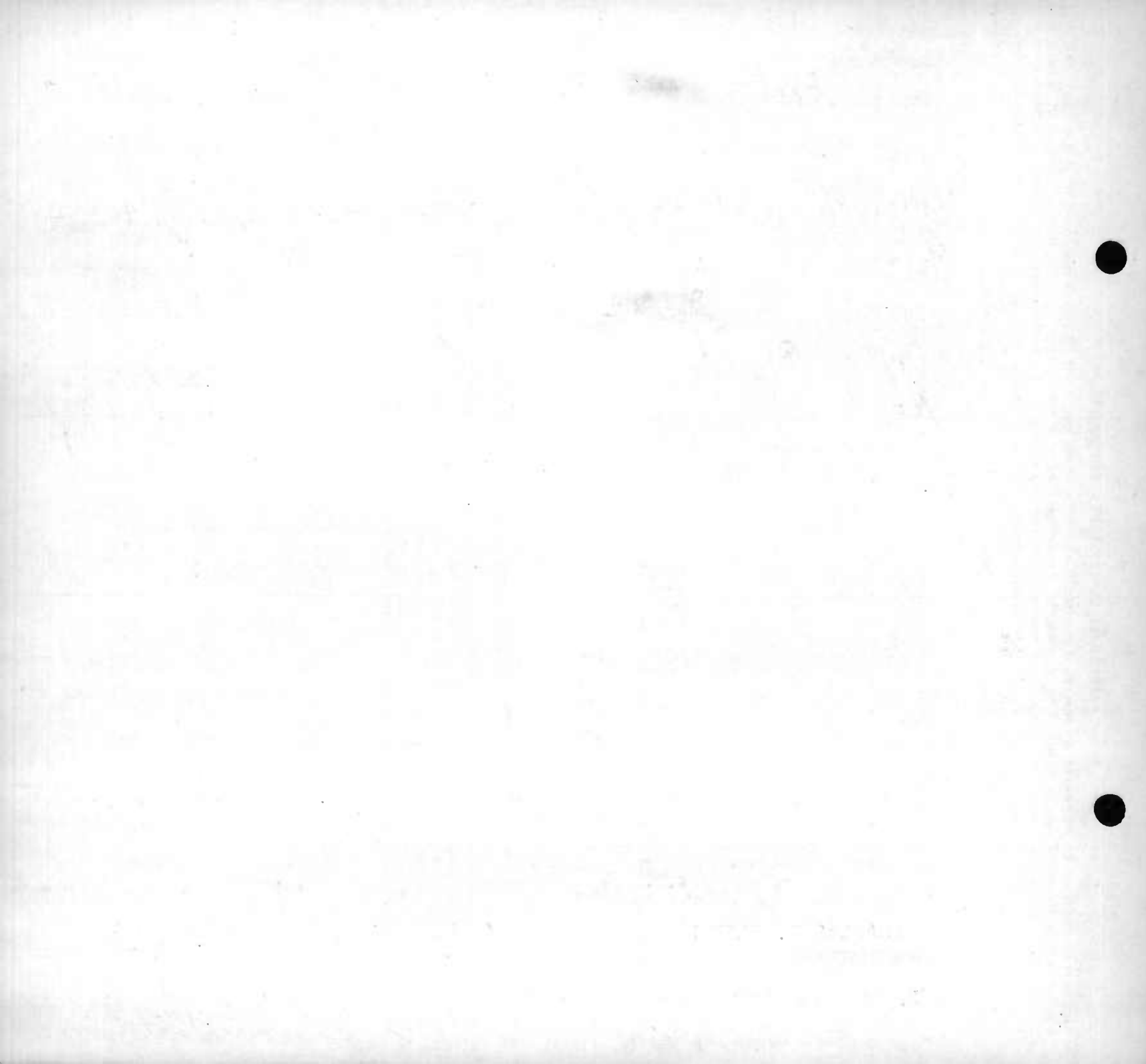
BIRTH NO. 65 6023		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 6023	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Reid, Alease</i>			2. DATE AND HOUR OF DEATH <i>June 7, 1965</i> 5 ⁵⁷ A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland University Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>15-04</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>2017 N. Pulaski Street</i>		
5. SEX <i>Female</i>	6. RACE <i>negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>4-16-11</i>	9. AGE (In years last birthday) <i>54</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Vaquin</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Julius Warrell</i>			14. MOTHER'S MAIDEN NAME <i>Elizabeth Turner</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Charlotte Warren</i> ADDRESS <i>5/2909 Dupont Ave #15</i>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(A) DUE TO <i>Squamous cell carcinoma 8 months</i> (B) DUE TO <i>of cervix with metastases</i> (C) _____		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>May 27</i> 19 <i>65</i> to <i>June 7</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>June 7</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Chee Fai Tse</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>6-7-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>CHEE FAI TSE</i>		23D. ADDRESS <i>University Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>6-9-65</i>	24C. NAME of CEMETERY or CREMATORY <i>Not Auburn Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>George A. Kuhn</i> ADDRESS <i>1348 N. Calhoun St</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

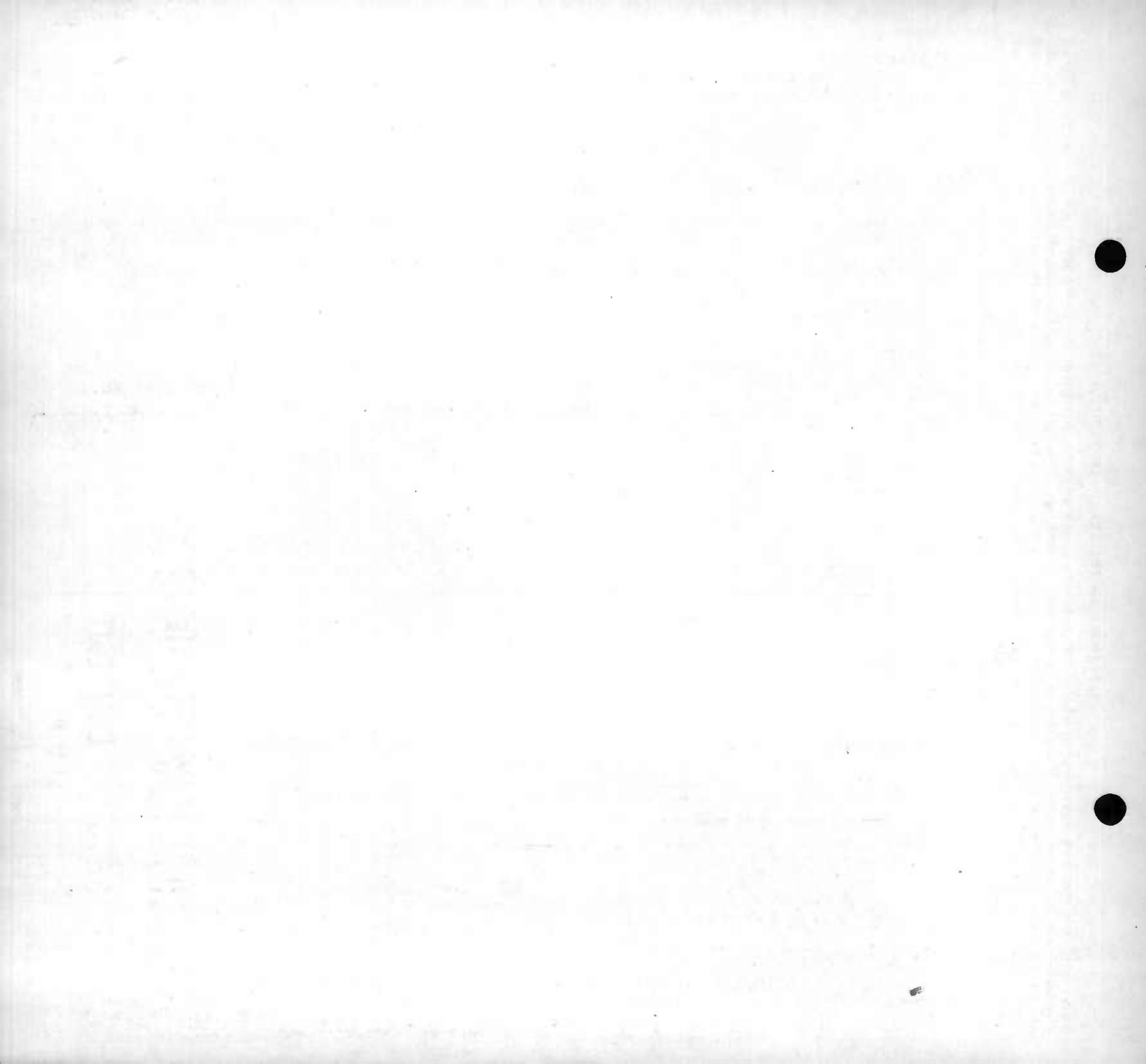
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 6024		CERTIFICATE OF DEATH		Registered No. 65 6024	
1. NAME OF DECEASED (Type or Print) Fritz Grund				2. DATE AND HOUR OF DEATH June 8, 1965 6:15 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 15-12 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3520 Greenspring Ave 11					
5. SEX Male	6. RACE Cauc	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 4-24-81		9. AGE (In years last birthday) 84		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher			10B. KIND OF BUSINESS OR INDUSTRY Henry Heil -		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME Fritz Grund				14. MOTHER'S MAIDEN NAME Anna Otto					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no (unknown)) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Fritz W Grund (son) 29 Address ELlicott City, Md.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 177X I CAUSE OF DEATH (A) CARCINOMA of PROSTATE DUE TO WITH METASTASES TO PERITONEAL, LIVER, LUNGS (B) DUE TO (C) BILATERAL BRONCHOPNEUMONIA 248				INTERVAL BETWEEN ONSET AND DEATH MO-Yrs. days					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (the hospital) attended the deceased from May 23 19 65 to June 8 19 65 , that (I) (we) last saw the deceased alive on June 8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Charles T. Fletcher M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 8, 1965			
23C. PHYSICIAN'S NAME (Type) CHARLES T. FLETCHER				23D. ADDRESS M.D. Union Memorial Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/11/1965		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town or county) (State) Woodlawn, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert S. Fairbank		25C. FUNERAL DIRECTOR Tickner's		ADDRESS Baltimore, Md. 21217 North Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

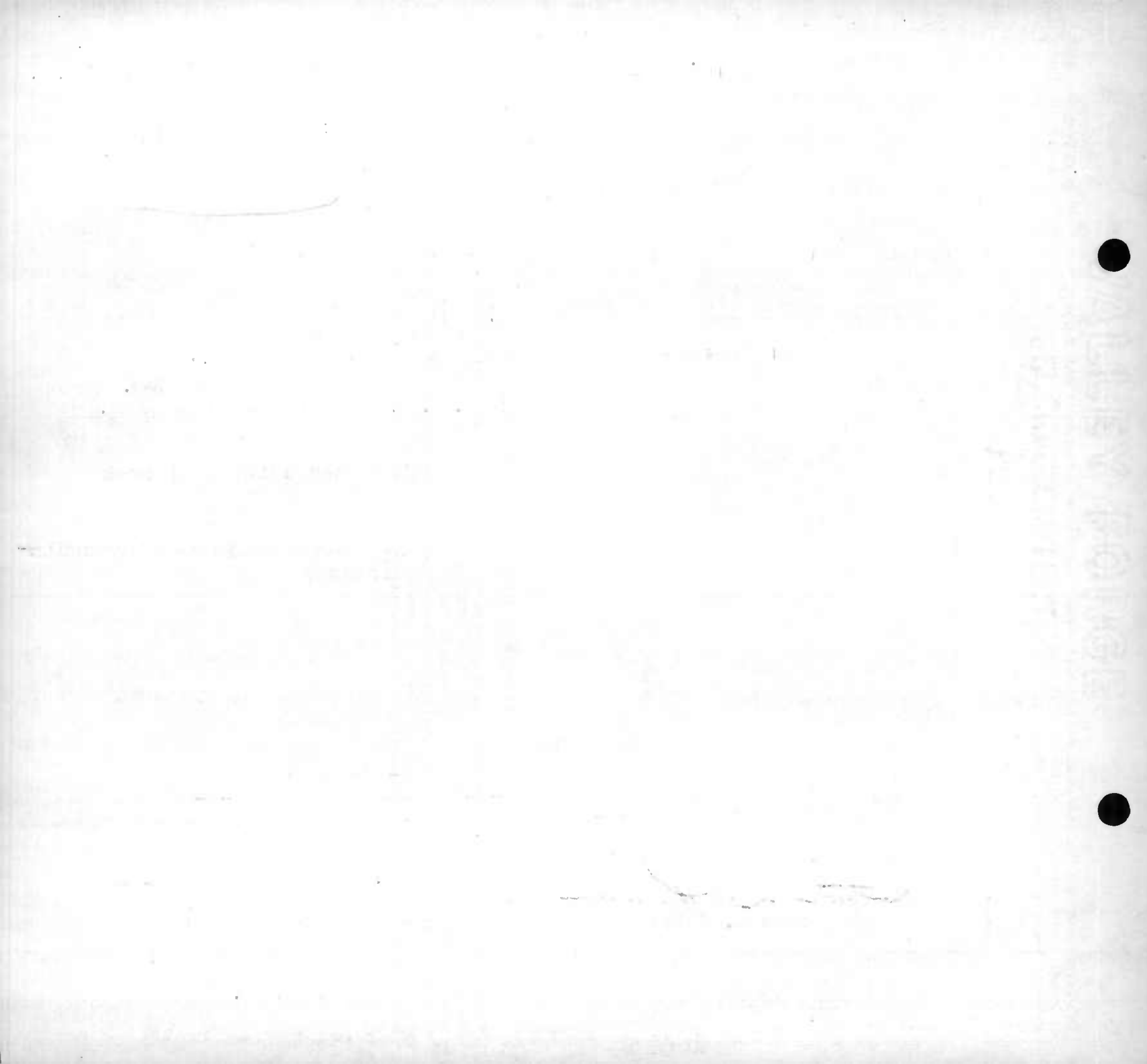
BIRTH NO. 65 6025				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6025	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Charlotte F. Wagner				2. DATE AND HOUR OF DEATH June 8, 1965 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 602 Somerset Road Baltimore, Maryland 21210		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 27-14	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 602 Somerset Road 21210			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH July 24, 1878	9. AGE (In years last birthday) 86	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Henry Frederick			
14. MOTHER'S MAIDEN NAME Marie ?				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None			
16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs. Joan C. Wallis Baltimore, Maryland 10			
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Coronary Heart Failure Hypertension (B) DUE TO Myocarditis (C) DUE TO Myocarditis - Coronary artery disease Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10-12 hr Gradual " "	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Feb 1948</u> to <u>June 8 1965</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>June 7 1965</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (did) (<u>did not</u>) view the body after death.							
23A. SIGNATURE <u>H. H. Hooley</u> M.D.				23B. DATE SIGNED 6-9-65			
23C. PHYSICIAN'S NAME (Type) <u>H. H. Hooley</u> M.D.				23D. ADDRESS 1403 Park Ave Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/10/1965		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR Wm. F. Dickerson Baltimore 21217			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

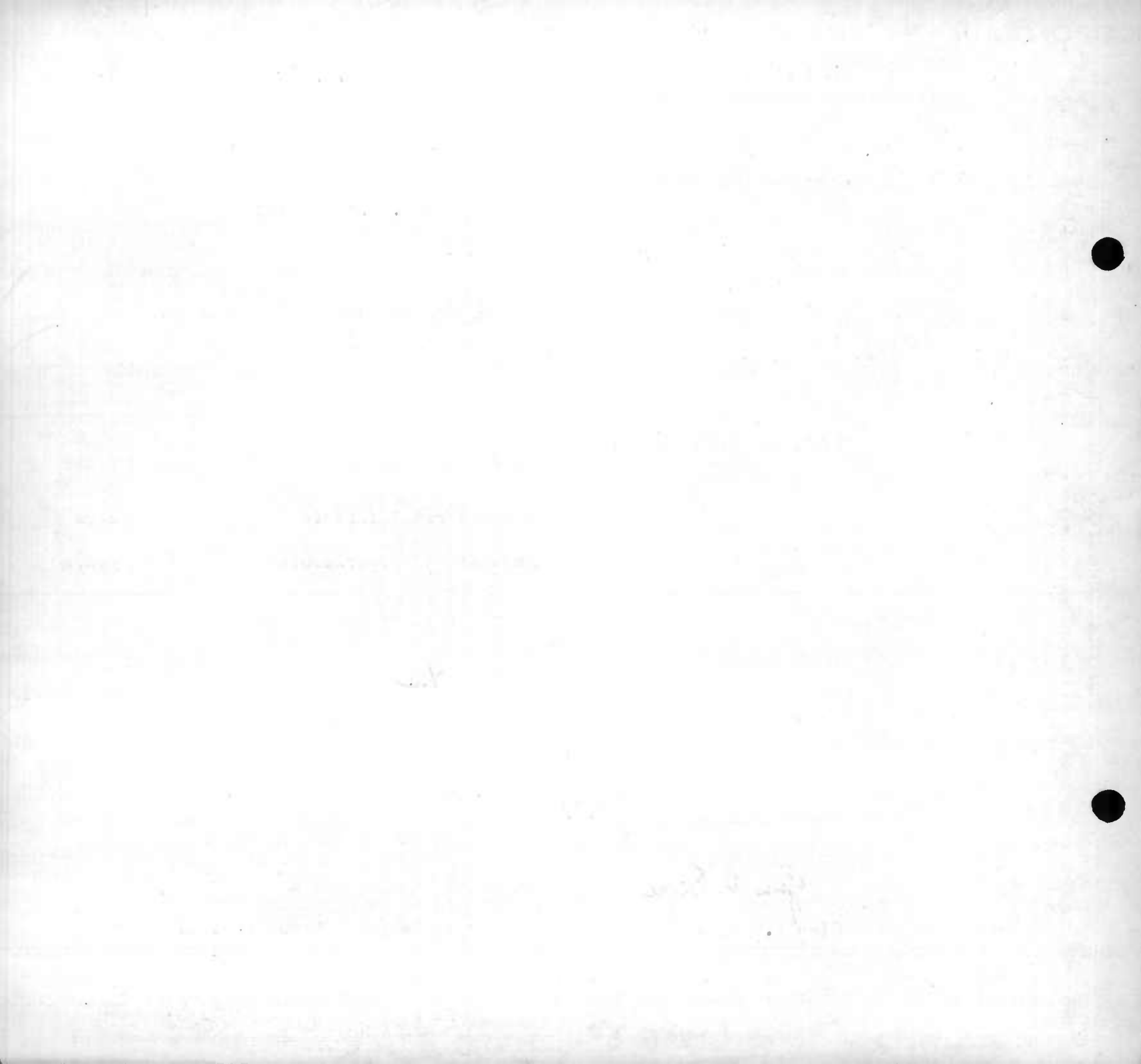
BALTIMORE CITY HEALTH DEPARTMENT										
65 6025 CERTIFICATE OF DEATH					Registered No. 1625694670 MYERS, LILLIE					
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) LILLIE M. MYERS					2. DATE AND HOUR OF DEATH 6-8-65 2:10 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 9-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 807 GORSUCH AVENUE 21218					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 6-23-74	9. AGE (In years last birthday) 90	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME LEVI PFEFFER PFEFFER					14. MOTHER'S MAIDEN NAME Sarah KATHERINE SHAEFFER.					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. C. W. Humbert		ADDRESS 7 Virginia Ave. Reisterstown, Md.			
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Aspiration Pneumonia					CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 week			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD (atherosclerotic cardiovascular disease)					(B) DUE TO		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? 4-23-65 TO				
22. I certify that (I) (this hospital) attended the deceased from 6-8-65 6:10 PM. to 6-8-65 19 , that (I) (we) last saw the deceased alive on 6-8-65 at 2:10 PM. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Steve L. Johnson M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 6-8-65		
23C. PHYSICIAN'S NAME (Type) Steve L. Johnson M.D.					23D. ADDRESS Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/10/1965		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery			24D. LOCATION (City, town, or county) (State) Woodlawn, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR Wm. J. Fickner + Sons			ADDRESS Balto, Md. 21217	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

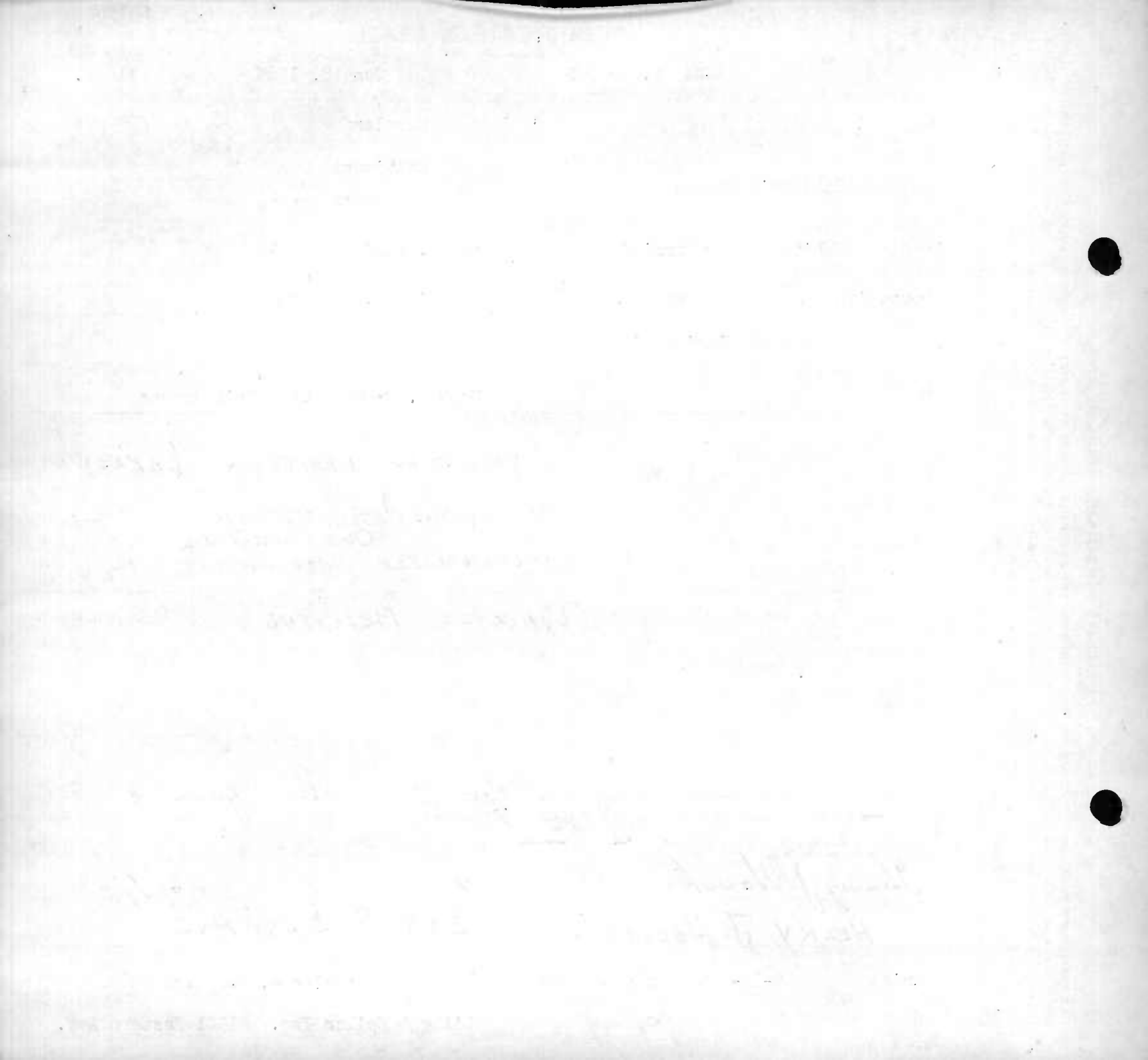
BALTIMORE CITY HEALTH DEPARTMENT				65 6027		Registered No.	
BIRTH NO.		65 6027		BALTIMORE CITY HEALTH DEPARTMENT		65 6027	
M.E. CASE NO.				65 6027			
1. NAME OF DECEASED (Type or Print) LUCILLE JONES				2. DATE AND HOUR OF DEATH 6/7/ 1965 7:00 P			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 15-02	
3 The Johns Hopkins Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1933 W. North Avenue			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-9-19	9. AGE (In years last birthday) 45	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jesse Hite				14. MOTHER'S MAIDEN NAME Lucy Keaton			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Silas Jones		ADDRESS 933 W. North Ave	
18. 5-93 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Acute renal failure DUE TO				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Chronic renal failure DUE TO		years	
				(C) Accelerated hypertension DUE TO		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/21/65 to 6/7 19 65 , that (I) (we) lost saw the deceased alive on 6/7/ 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Gino V. Segre				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/7/65	
23C. PHYSICIAN'S NAME (Type) Gino V. Segre				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE June 6, 1965		24C. NAME OF CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR Johns Hopkins		ADDRESS Baltimore Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6028				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6028	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ANNA T. BROWN				June 8, 1965		11 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
2543 Fait Avenue				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				2543 Fait Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		
Female	White	Married	May 13, 1889	76			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Baltimore, Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph Wisniewski							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				Hugh C. Brown		2543 Fait Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) MYOCARDIAL INFARCTION		UNKNOWN	
ANTECEDENT CAUSES				(B) HYPERTENSIVE ARTERIOSCLEROTIC		4 year	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO CARDIO-VASC. DISEASE			
				(C) GENERALIZED ARTERIOSCLEROSIS		UNKNOWN	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				DIABETES MELLITUS		UNKNOWN	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb. 8, 1960 to June 8, 1965, that (I) last saw the deceased alive on June 7, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Henry J. Houska						6/9/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
HENRY J. HOUSKA				333 S. EAST AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6-11-1965		Holy Redeemer		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 9 1965		Robert E. Talley		Lilly & Zeiler Inc.		1901 Eastern Ave.	



CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Carl Stachowiak

2. DATE AND HOUR OF DEATH

June 7, 1965

2:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

529 S. Potomac Street #21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

2-2-06

9. AGE (In years
last birthday)

59

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Painter

10B. KIND OF BUSINESS OR INDUSTRY

Fisher Body

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Joseph Stachowiak

14. MOTHER'S MAIDEN NAME

Rose Jankowski

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #21224

18. 002, 11

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)(A) _____
DUE TO

Cardiac Arrest

1 Minute

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) _____
DUE TO

Tuberculosis

(C) _____

Pulmonary Insufficiency 2 B

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 27, 19 65 to June 7, 19 65,
that (I) (we) last saw the deceased alive on June 7, 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

June 7, 1965

23C. PHYSICIAN'S
NAME (Type)

Dr. Howard K. Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland #24

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/11/65

24C. NAME of CEMETERY or CREMATORY

Holy Rosary Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, County Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUN 9 1965

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

ADDRESS

Lilly & Zeiler Inc. 1901 Eastern Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 6030		65 6030	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Catherine Williams.			6-6-65. 4:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
South Baltimore General Hospital 446 Light St.			Maryland. 2302		
5. SEX			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
F.			Baltimore. #21230.		
6. RACE			D. STREET ADDRESS (If rural, give location)		
W.			South Baltimore General Hospital 446 Light St.		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH		
Widow.			2-28-1890 75.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			9. AGE (In years lost birthday)		
None.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME			11. BIRTHPLACE (State or foreign country)		
Theodore Fangmann.			Maryland.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME		
			Josephine Finke		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
212-14-1387			Melvin Pierson, 1446 Light St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
260X I			Pulmonary Edema		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Diabetic Cerebrovascular		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 6-5 1965 to 6-6 1965, that (we) last saw the deceased alive on 6-6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Douglas Weir				6-7-65.	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Douglas Weir M.D.				South Baltimore General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-10-65		Holy Cross Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 9 1965		Robert E. Taylor M.D.		Flynn & Fleming, 1422 Light St.	

BIRTH NO. 65 6031 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ANTONIO CORNISH 2. DATE AND HOUR PRONOUNCED DEAD June 5, 1965 12:59 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTIMORE GENERAL HOSP. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 604 W. Hamberg St.

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 8. DATE OF BIRTH 8/20/63 9. AGE (In years last birthday) 22 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Richard Cornish 14. MOTHER'S MAIDEN NAME Annie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT ADDRESS Richard Cornish 604 W. Hamburg St.

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Craniocerebral injury DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 3 6-4-65 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Head injury 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) School yard 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) School #129- Barre & Ridgely Streets

21D. TIME OF INJURY (APPROX.) 6 4 65 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR? Fell off sliding board

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) John E. Adams, M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER DATE SIGNED 6-7-65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 6/8/65 23C. NAME of CEMETERY or CREMATORY Mt. Auburn 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT. JUN 9 1965 24B. NAME OF REGISTRAR Robert E. Farley 24C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 661 W. Barre St.

WALLER FORCE

ALL CONTENT

USA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 6032		Registered No. 65 6032	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WINKFIELD, Aubrey (NMI)		2. DATE AND HOUR OF DEATH June 6, 1965 10:55 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 644 Dover St.			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4/18/12	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Winkfield			14. MOTHER'S MAIDEN NAME Ada Pearson				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6/27/42 To 12/31/45			16. SOCIAL SECURITY NO. None		17. INFORMANT Records V.A. Hospital, Baltimore, Md. 21218		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Bronchogenic Carcinoma with extensive metastasis			19. CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 year		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO				
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 1 19 65 to June 6 19 65 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 6 19 65 and that <input checked="" type="checkbox"/> (our) opinion of death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE <i>J. Adatepe</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 7, 1965	
23C. PHYSICIAN'S NAME (Type) J. ADATEPE				23D. ADDRESS V.A. Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/10/65		24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 6611 Borne	

BIRTH NO. 65 6033		BALTIMORE CITY HEALTH DEPARTMENT		65 6033	
F-460		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD			
ANTHONY FULLER		6-7-65		7:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland			
SOUTH BALTIMORE GENERAL HOSPITAL - DOA		B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3429 Round Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	Colored	Never married	2/12/65	3	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
			Maryland	USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Frank Fuller		Gladys Kess			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		Frank Fuller 3429 Round Rd	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Acute upper respiratory infection			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) Sicklemia - Acute			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		M.D.		DATE SIGNED	
EXAMINER'S NAME (Type)		PETER W. RIECKERT, M.D.		6-7-65	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		6/9/65		Mt Auburn	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
JUN 9 1965		Robert E. Taylor, M.D.		Charles A. Rice 6614 Wilbarre St	

VALLEY FORCE

STATE OF IOWA

IN SENATE

January 11, 1901

REPORT

OF THE

COMMISSIONERS

OF THE

LAND OFFICE

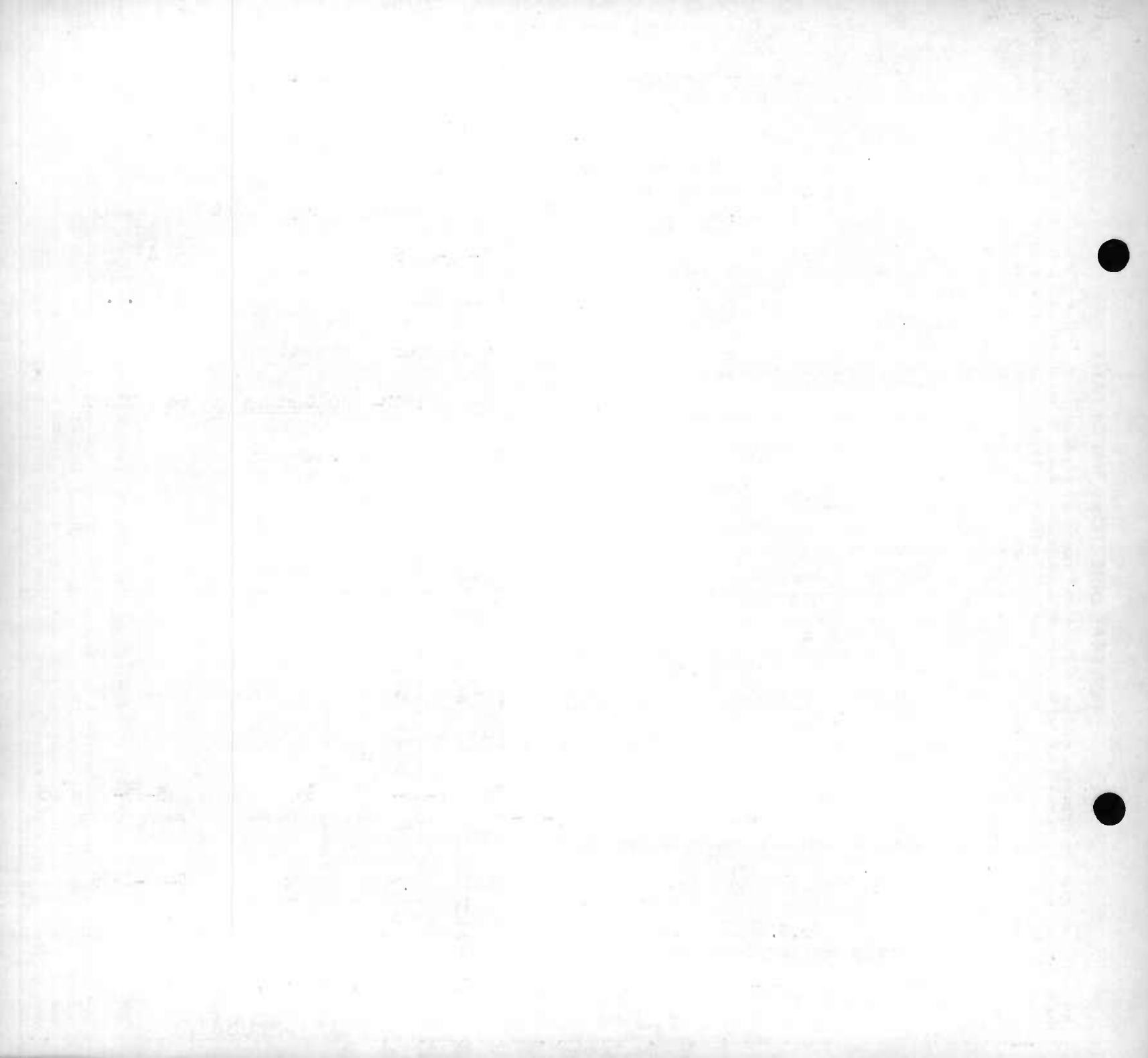
TO THE

LEGISLATURE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

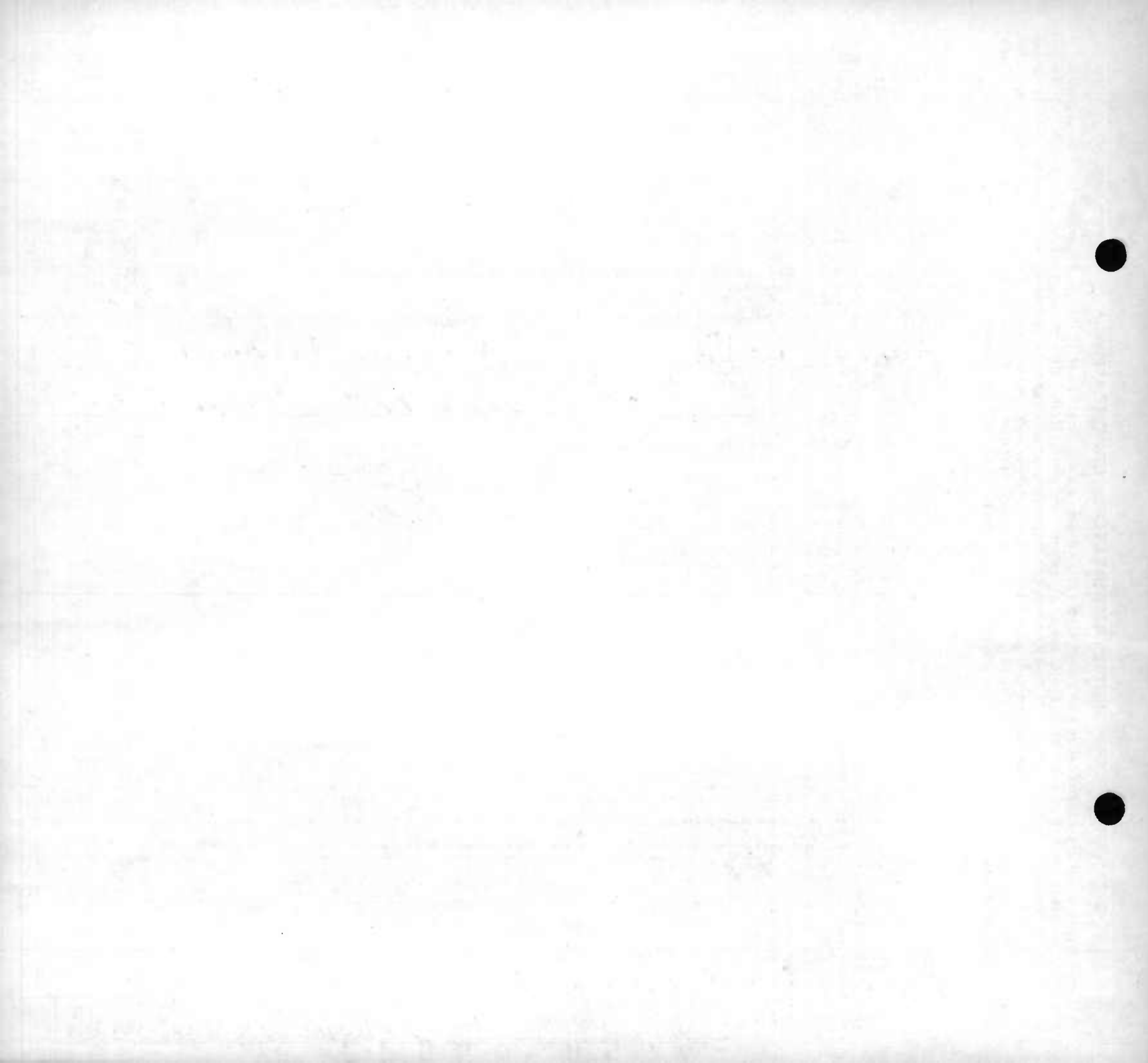
SAB 43-69-74		65-12213 65 6034		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 6034 ✓	
BIRTH NO. 65-12213				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Baby Boy Fenwick-Delores				2. DATE AND HOUR OF DEATH 5-29-1965 12.10A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 20-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2804 West Mulberry Street 21223			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 5-25-1965	9. AGE (in years last birthday) 4	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Delores Bennett			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224		
18. 757.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Heart Failure and Pulmonary Edema caused by Congenital Heart				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-25-19 65 to 5-29-19 65 , that (I) (we) lost saw the deceased alive on 5-29-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE S. Wayne Klein				M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-29-1965	
23C. PHYSICIAN'S NAME (Type) Dr. S. Wayne Klein				23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 6-4-1965		24C. NAME of CEMETERY or CREMATORY Baltimore City Hospitals		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6035	
BIRTH NO. 65 6035		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Henry Belt</u>		2. DATE AND HOUR OF DEATH <u>6/7/65</u> <u>11:45</u> P.M.	
3. PLACE OF DEATH <u>IN BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u> D. STREET ADDRESS (If rural, give location) <u>3919 Wabash Ave.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u>					
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	B. DATE OF BIRTH <u>4/6/30</u>	9. AGE (In years lost birthday) <u>35</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine operator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Henry Belt</u>		14. MOTHER'S MAIDEN NAME <u>ROXANA FREEMAN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>Korea</u>		16. SOCIAL SECURITY NO. <u>212-26-7162</u>		17. INFORMANT ADDRESS <u>Elaine Belt 3919 Wabash Ave.</u>	
18. <u>42221</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <u>Cerebral embolism and probable pulmonary embolism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days and 1 day</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Primary Myocardopathy</u>		<u>4 years</u>	
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/2</u> 19 <u>65</u> to <u>6/7</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>6/7</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ronald Rice</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/8/65</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <u>Sinai Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>6-11-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Balto, NATL</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 9 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>MORTON & DOTT 1701 LAWRENCE</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6036				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6036	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JAMES G. BOOKER				2. DATE AND HOUR OF DEATH 6/8/65 4:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) PROVIDENT HOSPITAL BALTO. 17, MD.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-11 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3304 DORCHESTER RD.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 4/5/81	9. AGE (In years lost birthday) 84	II Under 1 Yr. Months Days II Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		10B. KIND OF BUSINESS OR INDUSTRY Pharmacy		11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Stephen Booker				14. MOTHER'S MAIDEN NAME Sarah Jackson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 257-91-3350		17. INFORMANT DAUGHTER ADDRESS GRACE B. HUNT 3304 DORCHESTER RD.			
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anturmelate Heart Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Uremia due to Anturmelate Nephrosclerosis				CAUSE OF DEATH (A) Anturmelate Heart Disease DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 5 years			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 6, 1965 to June 8, 1965 , that (I) (we) last saw the deceased alive on June 8, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Roland T. Smoot M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 6/8/65			
23C. PHYSICIAN'S NAME (Type) ROLAND T. SMOOT				23D. ADDRESS 3817 COPLEY RD., BALTO. 15, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-12-65		24C. NAME OF CEMETERY or CREMATORY Union Cemetery		24D. LOCATION (City, town, or county) (State) Columbus, Ohio	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Fajen		25C. FUNERAL DIRECTOR ADDRESS Williams & McNabb - 818 E. Long St. Columbus, Ohio			

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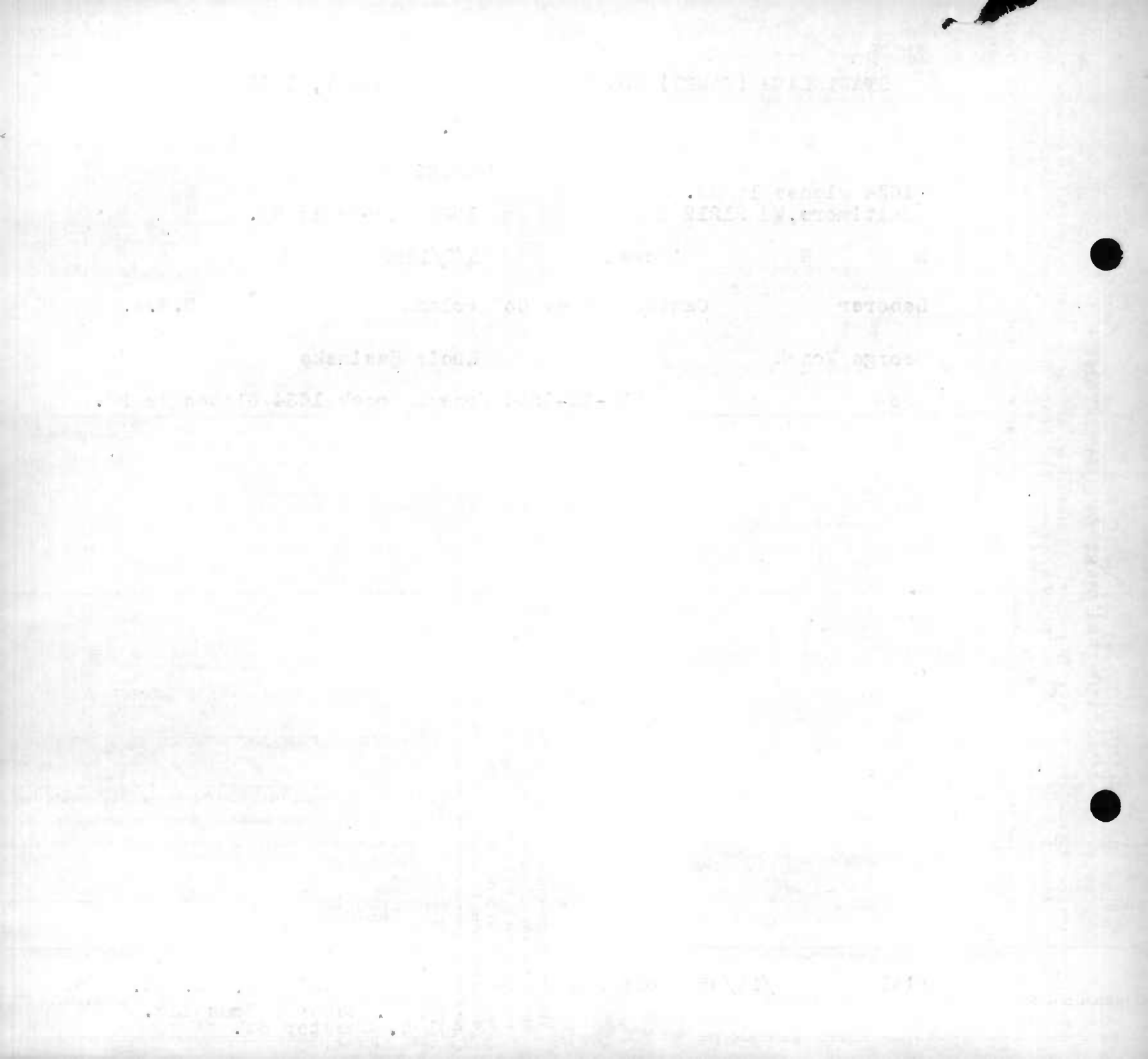
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

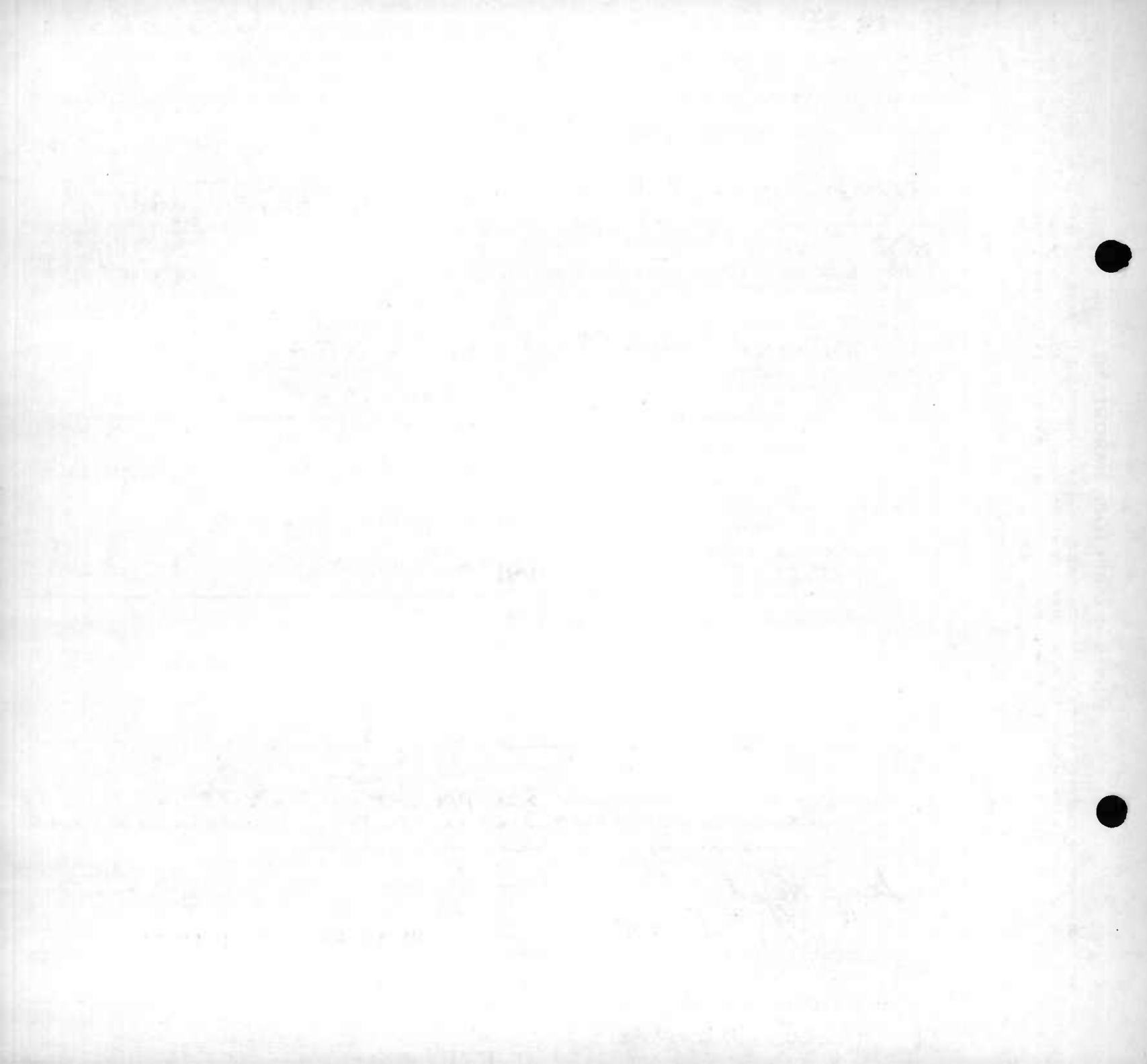
BIRTH NO.		65 6037		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6037	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
STANISLAUS (JAMES) NOSEK				2. DATE AND HOUR OF DEATH June 7, 1965 4 ¹⁶ P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
1634 Gleneagle Rd. Baltimore, Md 21212				Md. 27-38			
5. SEX 6. RACE 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
M W Widowed				Baltimore			
8. DATE OF BIRTH 9. AGE (In years last birthday)				D. STREET ADDRESS (If rural, give location)			
5/8/1880 85				1634 Gleneagle Rd.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Laborer				Poland			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
Canton Lumber Co				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Nosek				Lucia Basinska			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				218-10-5584			
17. INFORMANT				ADDRESS			
Joseph Nosek				1634 Gleneagle Rd.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				Anteriosclerotic Cardiovascular Disease			
ANTECEDENT CAUSES				(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
(C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
0							
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
No				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from January 1965 to June 7 1965							
that (I) (we) last saw the deceased alive on June 7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
William H. Fusting M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				6-8-65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
William H. Fusting M.D.				4230 Loch Raven Blvd.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				6/11/65			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Holy Rosary Cemetery				Baltimore, Co. Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
JUN 9 1965				Robert E. Fusting			
25C. FUNERAL DIRECTOR				25D. ADDRESS			
John M. Weber & Sons Inc.				401 S. Chester St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

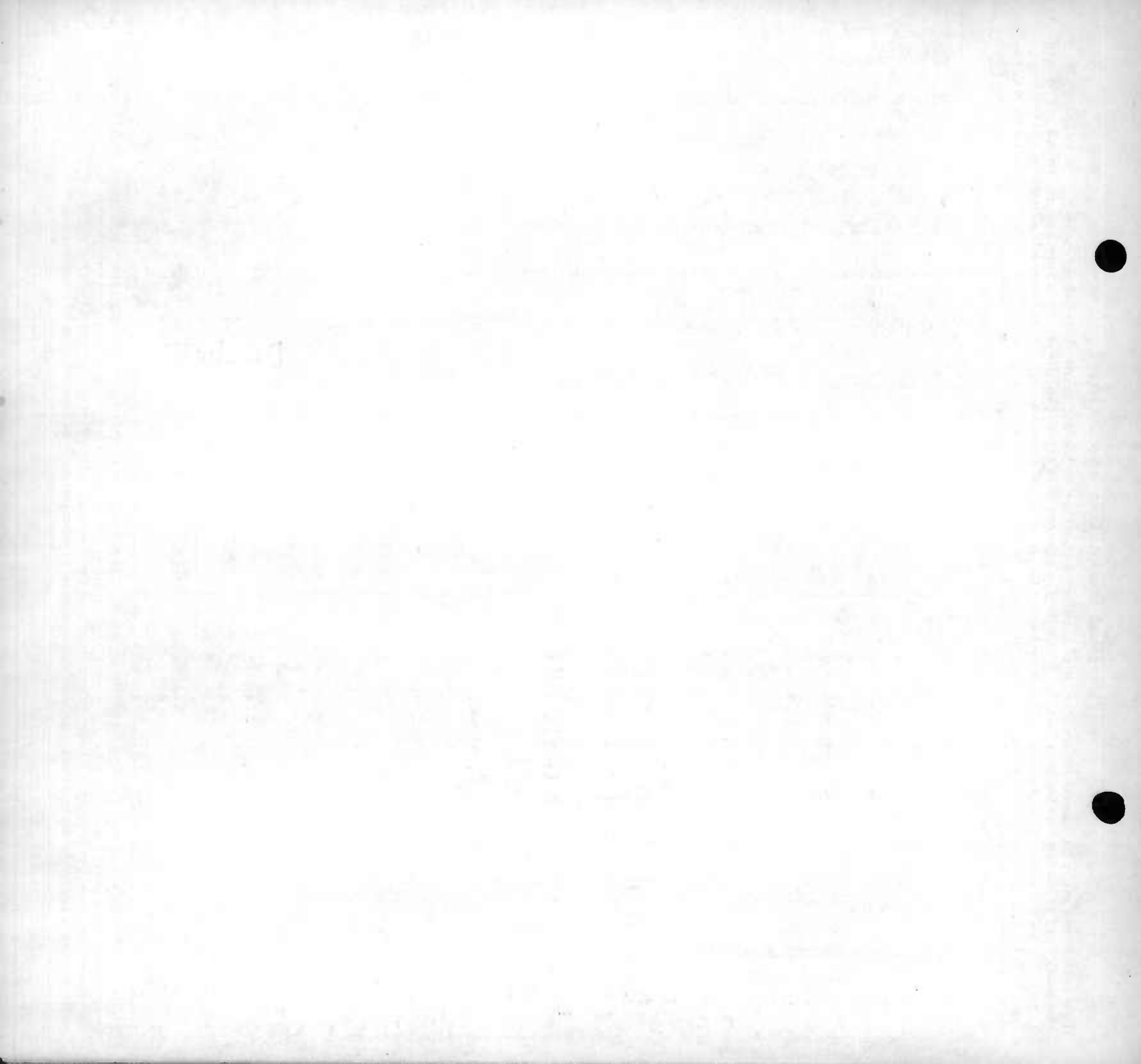
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6038	
BIRTH NO. 65 12933		M.E. CASE NO. 65 6038	
1. NAME OF DECEASED (Type or Print) STOVER, BABY BOY		2. DATE AND HOUR OF DEATH 5-29-1965 4-30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3418 DUNHAYEN Rd.	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) -	8. DATE OF BIRTH 5-29-65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10B. KIND OF BUSINESS OR INDUSTRY -	9. AGE (In years last birthday) -
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mr. ANTHONY STOVER		14. MOTHER'S MAIDEN NAME Mrs. NORITA STOVER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -	17. INFORMANT PARENTS
18. 270.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Rh incompatibility		INTERVAL BETWEEN ONSET AND DEATH 4-00 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Heart failure, hydrops		(B) Brain anoxia	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. -			
19A. DATE OF OPERATION -	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -	20A. AUTOPSY? (Yes or No) yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> -	21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 3:30 PM 5-29-1965 to 4:30 PM 5-29-1965 , that (I) (we) last saw the deceased alive on 4:30 PM 5-29-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Iraj Nejat		23B. DATE SIGNED 5-29-65	
23C. PHYSICIAN'S NAME (Type) IRAJ NEJAT		23D. ADDRESS U. UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) -	24B. DATE JUN 9 1965	24C. NAME of CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL	24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965	25B. NAME OF REGISTRAR Robert E. Farley M.D.	25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHO	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-20411 65 6039				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6039	
1. NAME OF DECEASED (Type or Print) Baby Boy Curtis				2. DATE AND HOUR OF DEATH 6/3/65 2:20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSP of Baltimore				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 16-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1415 Lawrence St			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) S	8. DATE OF BIRTH 5/26/65	9. AGE (In years last birthday) 7	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry				14. MOTHER'S MAIDEN NAME Nancy Duckett			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PREMATURE				CAUSE OF DEATH Premature		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/26/65 19 to 6/3/65 19, that (I) (we) last saw the deceased alive on 6/3/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Gregory Sueda				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/3/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE JUN 9 1965		24C. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS MEDICAL SCHOOL		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No.	
BIRTH NO. <u>65-14049</u>		<u>65</u>		<u>6040</u>		CERTIFICATE OF DEATH				<u>65</u> <u>6040</u>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Baby Crin Withers</u>						2. DATE AND HOUR OF DEATH <u>6/3/65</u> <u>10.45</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Lutheran Hospital of Maryland</u>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-06</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2844 W. North Ave. 21216</u>					
5. SEX <u>F</u>		6. RACE <u>C</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <u>6/2/65</u>		9. AGE (In years lost birthday) <u>1</u> <u>7</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>Rosevelt Lee</u>						14. MOTHER'S MAIDEN NAME <u>Julia Brown</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
18. <u>768.5 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) <u>aspiration?</u> DUE TO (B) <u>septicemia?</u> DUE TO (C) <u>immaturity</u>			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>6/2/</u> 19 <u>65</u> to <u>6/3/</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>6/3/</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Hossein Golpira</u>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>6/3/65</u>		
23C. PHYSICIAN'S NAME (Type) <u>HOSSEIN GOLPIRA</u>						23D. ADDRESS M.D. <u>ANATOMY BOARD OF MARYLAND</u> <u>JOHNS HOPKINS MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BCHD</u>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>JUN 9 1965</u>		24C. NAME OF CEMETERY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>		24D. LOCATION <u>City, town, or county</u>		24E. STATE <u>(State)</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 9 1965</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>				25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 13672 65 6041				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6041	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Dawn Marie Bloom				2. DATE AND HOUR OF DEATH JUNE 7-65 12:58 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSP.				A. STATE MD. B. COUNTY 13-05			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #11			
				D. STREET ADDRESS (If rural, give location) 3111 ELM AVENUE			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH June 7-65	
9. AGE (In years last birthday) 40		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Leonard Frank				14. MOTHER'S MAIDEN NAME Sandra Marie Bloom			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. —		17. INFORMANT MOTHER	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 276X1 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Senility, generalized</u> (B) <u>—</u> (C) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 12:58 AM 6/7/65 to 12:58 AM 6/7/65, that (I) (we) last saw the deceased alive on 6/7/19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Edgardo P. Villanueva M.D.				23B. DATE SIGNED 6-7-65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE JUN 9 1965		24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL		24D. LOCATION (City, town or county) (State) BALTIMORE MORTUARY SERVICE - BCHD	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Fasham		25C. FUNERAL DIRECTOR ADDRESS			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6042		BALTIMORE CITY DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 6042	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>THOMAS George Patrick</u>		2. DATE AND HOUR OF DEATH <u>JUNE 3, 1965</u> <u>12⁵⁰</u> P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>md. GEN. Hosp.</u>		A. STATE <u>md.</u> B. COUNTY <u>BALTO.</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO #22</u>		<u>5300</u>	
		D. STREET ADDRESS (If rural, give location) <u>3419 SOLLERS PL. RD.</u>			
5. SEX <u>MALE</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>N.B.</u>	8. DATE OF BIRTH <u>JUNE 3, 1965</u>	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <u>4</u> <u>30</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>HAROLD McKendrick Patrick</u>			14. MOTHER'S MAIDEN NAME <u>NORMA RAE BOWERMAN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>mother</u> <u>SAME</u>	
18. <u>759.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary atelectasis</u>		CAUSE OF DEATH (A) DUE TO <u>Multiple congenital malformations</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <u>Possible 18-Trisomy Chromosome defect</u>			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yes</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>JUNE 3</u> 19 <u>65</u> to <u>JUNE 3</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>JUNE 3</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Paul A. Mullan</u>				23B. DATE SIGNED <u>6/3/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>PAUL A. MULLAN</u>				23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u>	
				23E. M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>JUN 9 1965</u>		24C. NAME of CEMETERY or CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>		24D. LOCATION (City, town, or county) (State) <u>MORTUARY SERVICE - BCHD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 9 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR'S ADDRESS	

Book 11
Vol. 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65-67837 65 6043					CERTIFICATE OF DEATH					Registered No. 65 6043				
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) Adderley Baby Boy					2. DATE AND HOUR OF DEATH 5/10/65 - 6:40 PM				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-16					M.				
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital of Balto, Inc					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore									
					O. STREET ADDRESS (If rural, give location) 2811 Virginia Ave									
5. SEX M		6. RACE C		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married		8. DATE OF BIRTH 4/1/65		9. AGE (In years last birthday) 19		If Under 1 Yr. Months Ooys		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Md.				
12. CITIZEN OF WHAT COUNTRY? USA					13. FATHER'S NAME Albert Adderley					14. MOTHER'S MAIDEN NAME Mary				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. -					17. INFORMANT ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 7-9-31					CAUSE OF DEATH (A) Sepsis - (pneumonia) DUE TO (B) Prematurity DUE TO (C) Twinning 18					INTERVAL BETWEEN ONSET AND DEATH 14 hrs				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
21. DATE OF OPERATION					22. CONDITION FOR WHICH OPERATION WAS PERFORMED					23. AUTOPSY? (Yes or No) Yes				
24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
27. TIME OF INJURY (APPROX.)					28. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					29. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from 4-1- 19 65 to 5-10- 19 65 , that (2) (we) lost saw the deceased alive on 5/10/ 19 65 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.														
23A. SIGNATURE S. Sidman										23B. DATE SIGNED 5/10/65				
23C. PHYSICIAN'S NAME (Type) Sidney B. Seidman										23D. ADDRESS Sinai Hospital of Baltimore				
24A. BURIAL, CREMATION, REMOVAL (Specify)					24B. DATE JUN 9 1965					24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL				
24D. LOCATION (City, town, or county) (State)					24E. LOCATION (City, town, or county) (State)					24F. LOCATION (City, town, or county) (State)				
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965					25B. NAME OF REGISTRAR Robert E. Fairbank					25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD				

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M. C.

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Albert Heine

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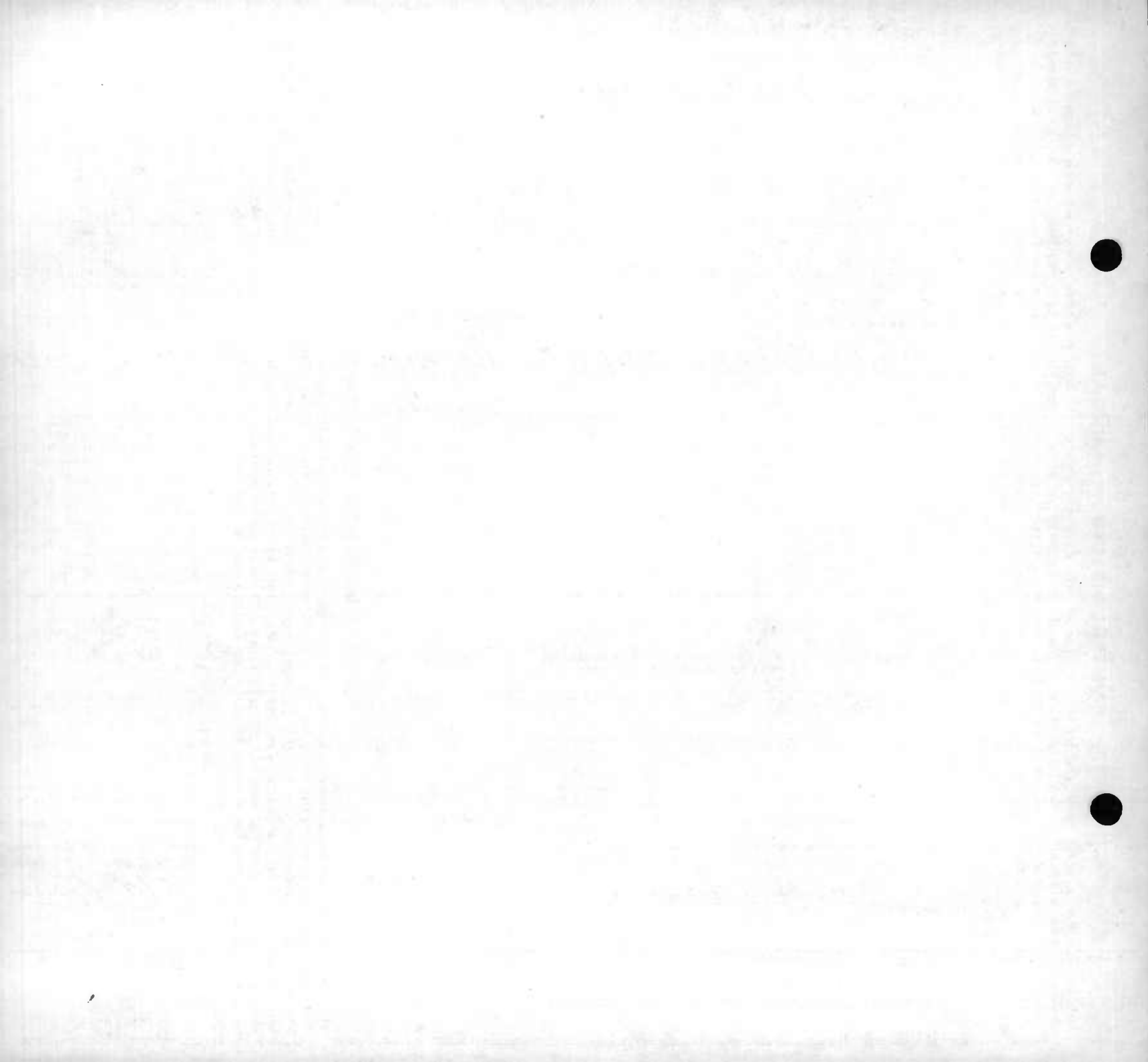
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

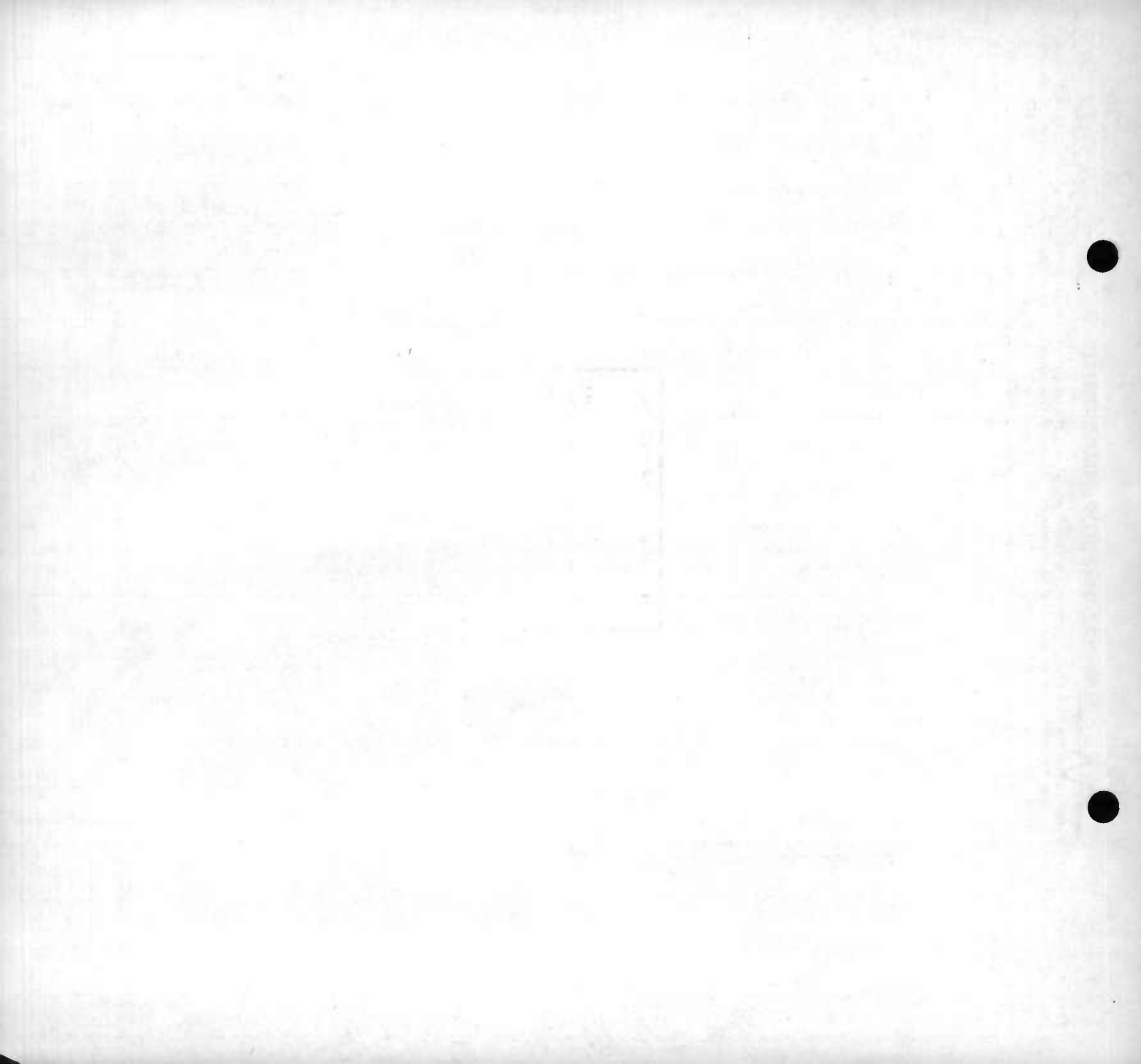
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No.	
BIRTH NO. <u>65-12236 65 6044</u>							
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>David William Byrne</u>		2. DATE AND HOUR OF DEATH <u>5/21/65 1 35 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>8-01</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND General Hospital</u>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore #13</u>			
		D. STREET ADDRESS (If rural, give location) <u>3409 Lyndale Ave</u>					
5. SEX <u>male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>N.B.</u>	8. DATE OF BIRTH <u>5/21/65</u>	9. AGE (In years lost birthday) <u>8 1</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Robert Byrne</u>		14. MOTHER'S MAIDEN NAME <u>Patricia Mathilda Gessner</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>mother</u>		ADDRESS <u>Same</u>	
18. <u>774X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <u>Pulmonary Immaturity</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Congenital absence of kidneys</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5-21-65</u> 19 <u>65</u> to <u>5-21-65</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>5-21-65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Steven J. Ahamedis</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5/21/65</u>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>JUN 9 1965</u>		24B. NAME OF CEMETERY OR CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>		24C. LOCATION (City, town, or County) (State) <u>MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 8 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Registered No. 65 6045

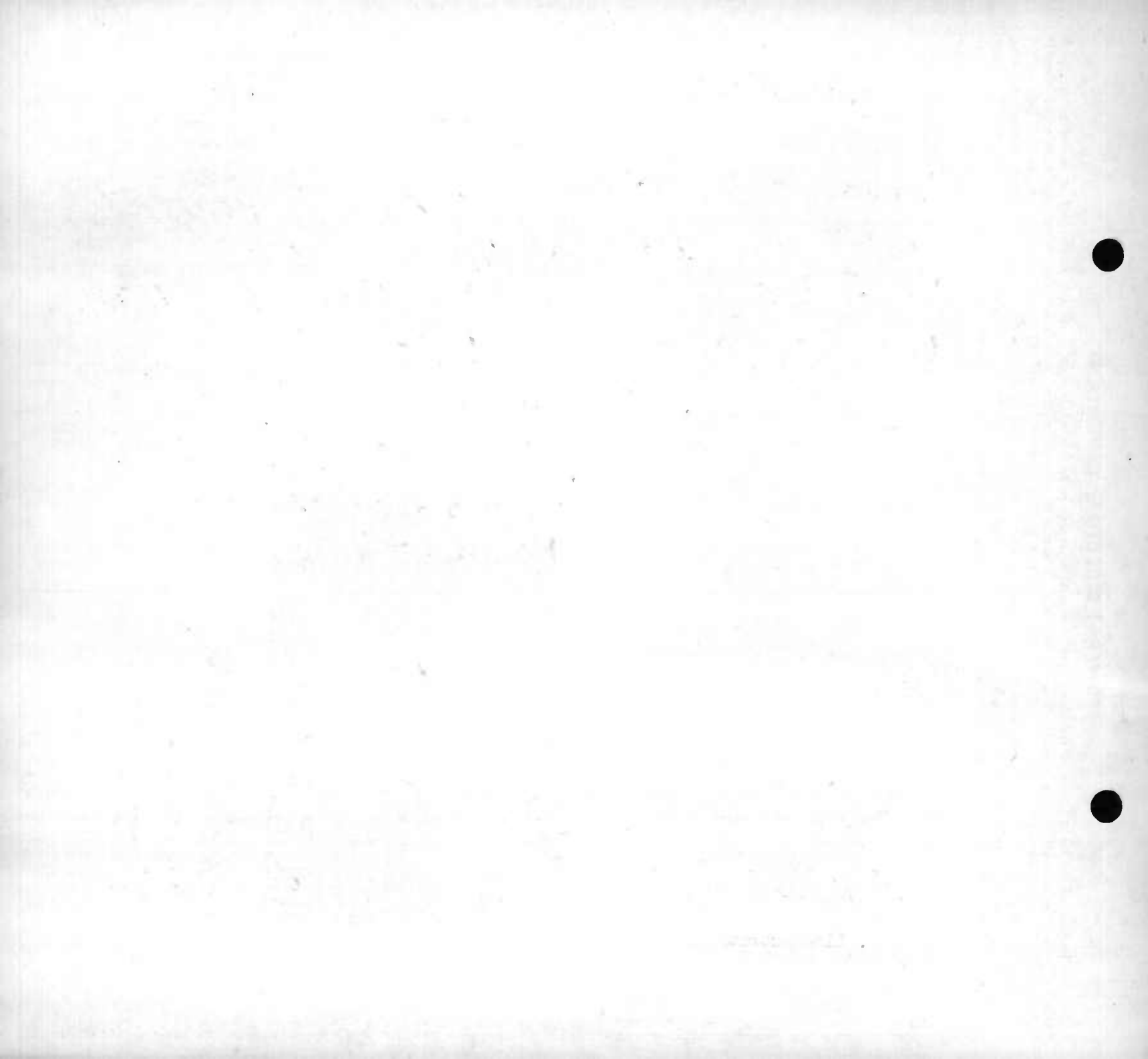
VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

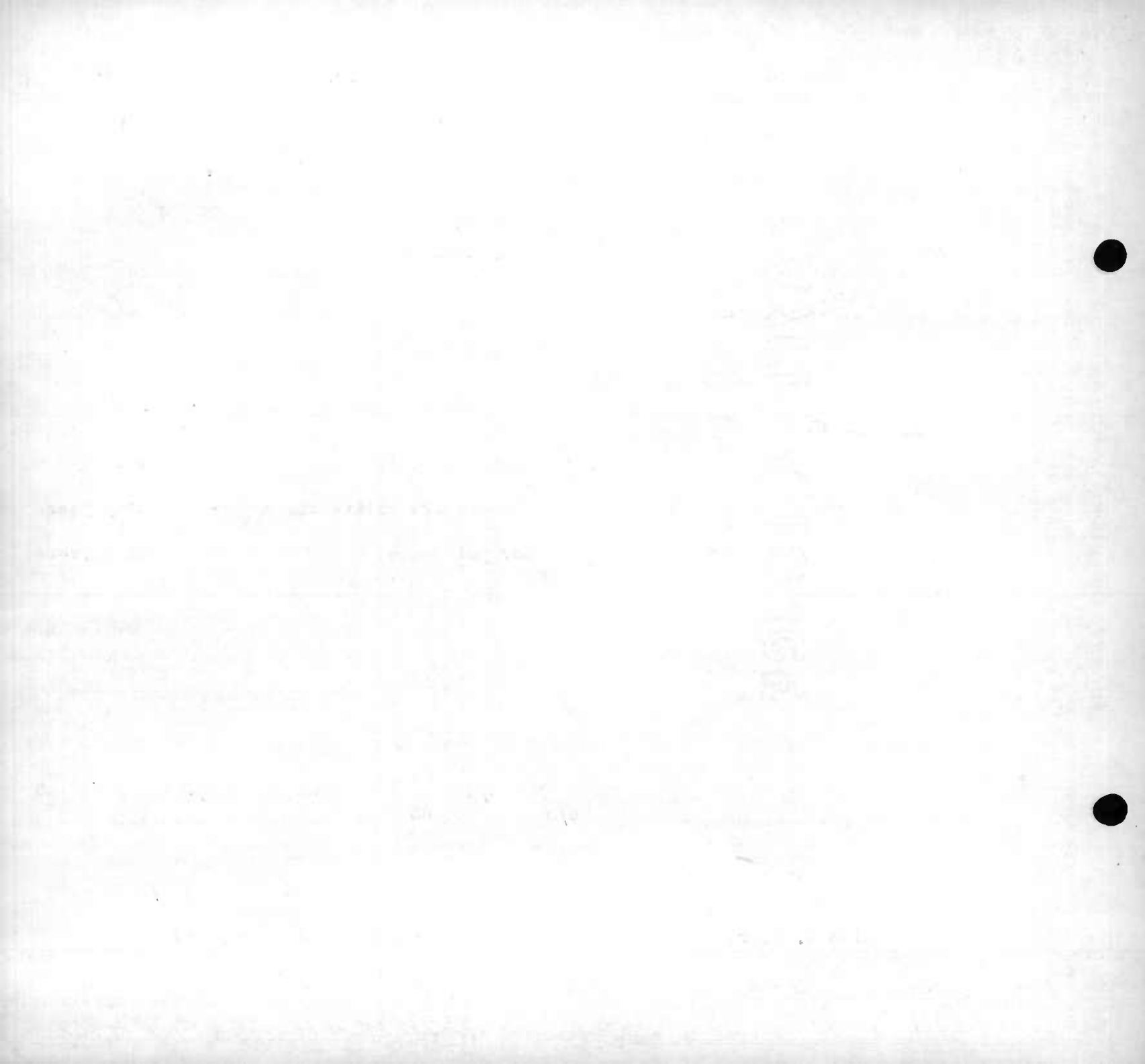
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6046	
BIRTH NO. 65 6046				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Adams, Rorie			2. DATE AND HOUR OF DEATH 6-7-65 1:35 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Mo. B. COUNTY 16-02		
5. SEX F 6. RACE N 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married			8. DATE OF BIRTH 7/15/13 9. AGE (In years last birthday) 51		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			11. BIRTHPLACE (State or foreign country) South Carolina		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Walter Wiley			14. MOTHER'S MAIDEN NAME Lula -		
15. Was Deceased Ever in U. S. Armed Forces? (Yes or no) (If yes, give war or dates of service) ?			16. SOCIAL SECURITY NO. ?		
17. INFORMANT Hospital chart			ADDRESS		
18. 441X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Uremia			INTERVAL BETWEEN ONSET AND DEATH ? months		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis			? years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-7-65 to 6-7-65 and that (I) (we) last saw the deceased alive on 6-7-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D. Lindenstruth M.D.				23B. DATE SIGNED 6-7-65	
23C. PHYSICIAN'S NAME (Type) D. Lindenstruth				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-11-65		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) Baltimore		24E. (State) md			
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR E.O. Wilson	
				ADDRESS 1600 Broadway Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 6047					CERTIFICATE OF DEATH				
Registered No. 65 6047									
1. NAME OF DECEASED (Type or Print) ANNIE JESTER					2. DATE AND HOUR OF DEATH 6/5/65 4:20 P				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 3-01				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
					D. STREET ADDRESS (If rural, give location) 409 SOUTH DALLAS STREET				
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 6-5-65	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME RANDOLPH JESTER			14. MOTHER'S MAIDEN NAME ANNIE RICE						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.			16. SOCIAL SECURITY NO.		17. INFORMANT Daisy Jones 212 Lila Court				
18. 502.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) Acute bronchial asthma			CAUSE OF DEATH (A) DUE TO Chronic bronchitis and emphysema			INTERVAL BETWEEN ONSET AND DEATH one day			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO Cer pulmonale			many years			
(C)						many years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/4 19 65 to 6/5 19 65 , that (I) (we) last saw the deceased alive on 6/5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Gino V. Segre						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/5/65	
23C. PHYSICIAN'S NAME (Type) Gino V. Segre			23D. ADDRESS M.D. Johns Hopkins Hospital						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-12/1965		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cmt		24D. LOCATION (City, town, or county) (State) Brooklyn Md			
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR Edmond Wilson 1015 Brantley Rd			



BIRTH NO.

65

6048

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Thomas M. Clements, (Clements)

2. DATE AND HOUR PRONOUNCED DEAD

June 5, 1965

9:35 P.^{M.}

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3420 Dillon Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

March 26, 1897

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

No. 3 Grain Elevator

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Clements

14. MOTHER'S MAIDEN NAME

Mary Potts

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W. 1

16. SOCIAL
SECURITY NO.

215-03-0374

17. INFORMANT

Hilda C. Clements

ADDRESS

3420 Dillon Street #24

18.

4-22-1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
June 6, 196523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-9-65

23C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

(City, town, or county)

(State)

7225 Eastern Blvd. Balto. 24, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

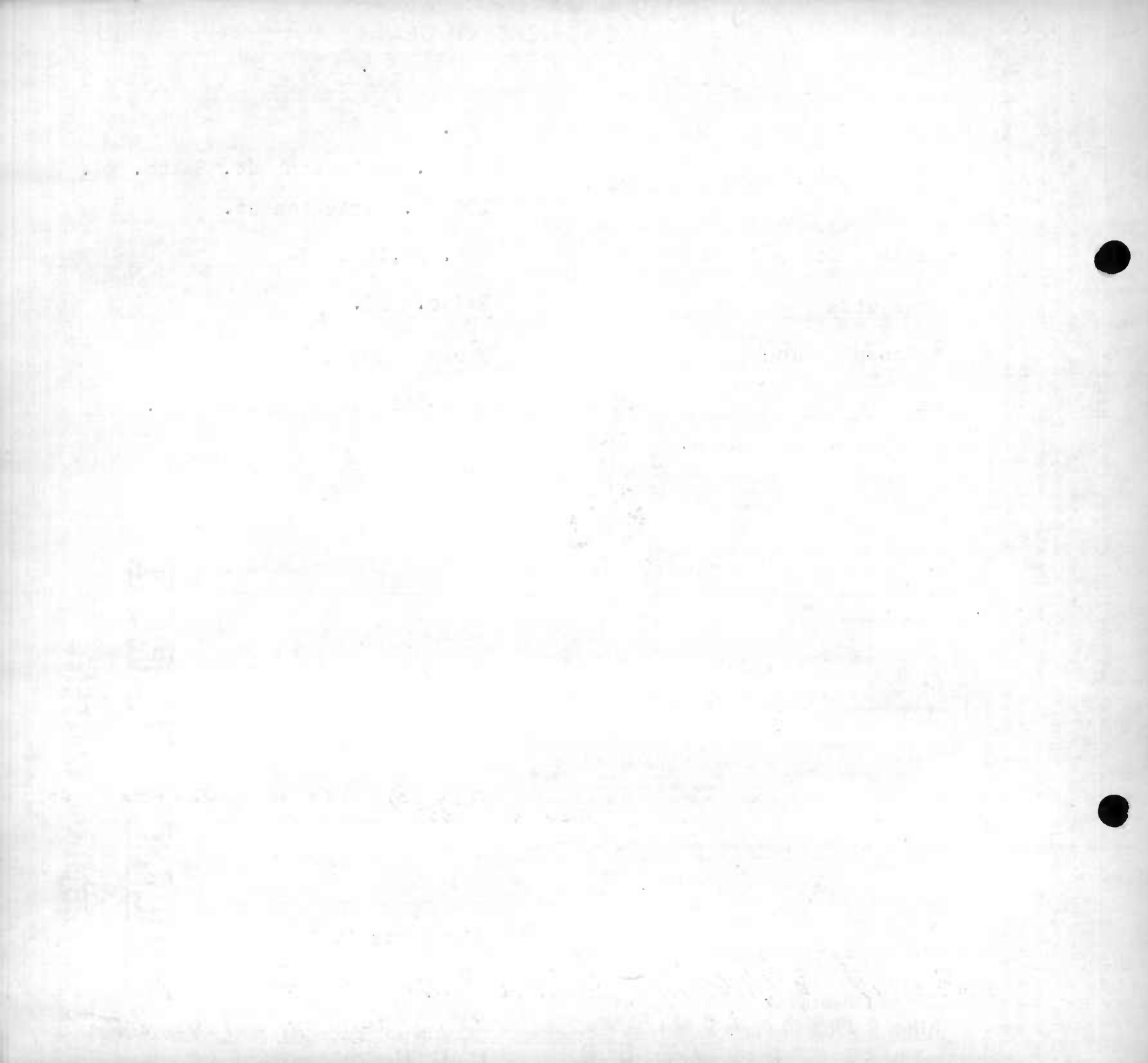
Charles S. Zeiler - 901 S. Conklin St. per E. S.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 6049	
BIRTH NO. 65 6049		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Pauline Cole</i>		2. DATE AND HOUR OF DEATH <i>6/5/65 3:15 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital</i>		A. STATE <i>Md.</i>		B. COUNTY <i>18-02</i>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		<i>1020 W. Lexington St. Balto. Md.</i>			
		D. STREET ADDRESS (If rural, give location)			
		<i>1020 W. Lexington St.</i>			
5. SEX <i>Female</i>	6. RACE <i>Colored</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widow</i>	8. DATE OF BIRTH <i>Sept. 22, 1890</i>	9. AGE (In years lost birthday) <i>74</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>
			11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Joseph Jones</i>			14. MOTHER'S MAIDEN NAME <i>Sarah Brown</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>none</i>		
17. INFORMANT <i>David Cole 1633 Morland Ave.</i>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			<i>Cerebral Thrombosis</i>		
ANTECEDENT CAUSES			(A) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
II			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <i>June 5, 1965</i> to <i>June 5, 1965</i> , that (I) (we) last saw the deceased alive on <i>June 5, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>D. J. Kuntz</i>				23B. DATE SIGNED <i>6/5/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>M.D.</i>				23D. ADDRESS <i>Sinai Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>6/9/1965</i>		<i>Mt. Auburn Cem. Balto. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairley</i>		25C. FUNERAL DIRECTOR <i>Williams Funeral Home 3197 Schroeder St.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
65 6050					65 6050					
BIRTH NO.					Registered No.					
M.E. CASE NO.					2. DATE AND HOUR OF DEATH					
1. NAME OF DECEASED (Type or Print) McCaopen Helen					6/4/65 2:50 PM					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL					A. STATE MARYLAND					
					B. COUNTY Baltimore					
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Edgemere					D. STREET ADDRESS (If rural, give location) 3111 Newton Rd					
					21219					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 2-28-09	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME FRANK C. MORRISON					14. MOTHER'S MAIDEN NAME FLORENCE GREEN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 214-20-6175		17. INFORMANT husband, Albert T. Mc Cadden					
18. 381.01					CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO Pulmonary atelectasis					
					(B) DUE TO Portal cirrhosis					
					(C) —					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Advanced chronic liver					INTERVAL BETWEEN ONSET AND DEATH					
					—					
19A. DATE OF OPERATION 3-5-23-65					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED allous		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED White <input type="checkbox"/> At Work Not White <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from JUNE 1 19 65 to JUNE 4 19 65 , that (I) (we) last saw the deceased alive on JUNE 4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Joseph J. Marshall					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 6/4/65		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D. Md. General Hosp. Balto. Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 8-1965		24C. NAME of CEMETERY or CREMATORY Sacred Heart of Jesus		24D. LOCATION (City, town, or county) (State) German Hill Rd. Dundalk, 21222 Md.				
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Feltner		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, 21222						

200 9

Mr. Robert [illegible]

Marland Baltimore

Marland (General)

Baltimore
311 North St

Marland

F W

224

Marland
Flower Green

Retired
Frank Morris

~~Marland~~
Baltimore

Admission [illegible]

11/10

8-23-07

200 9

200 9

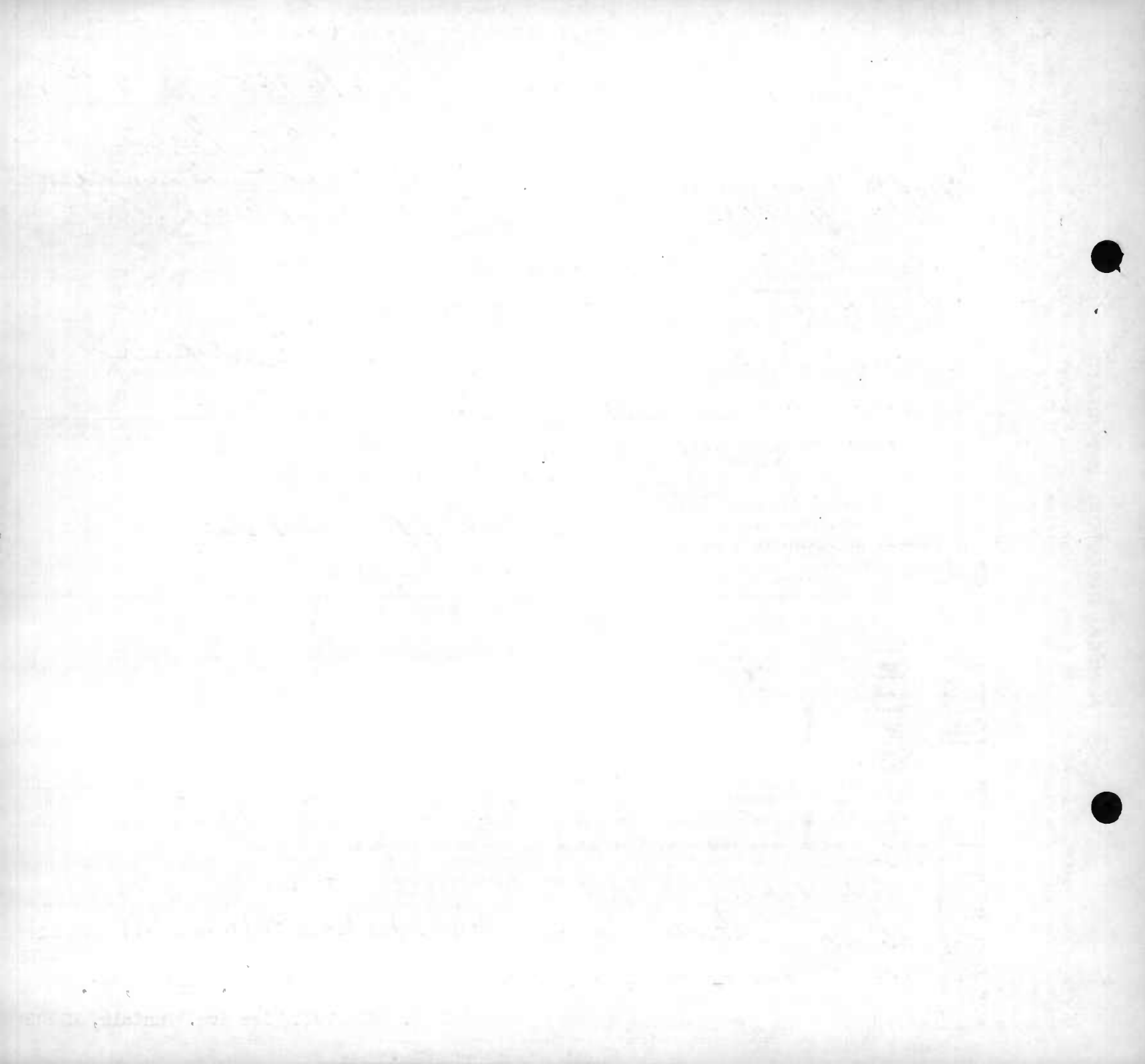
200 9

John P. [illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

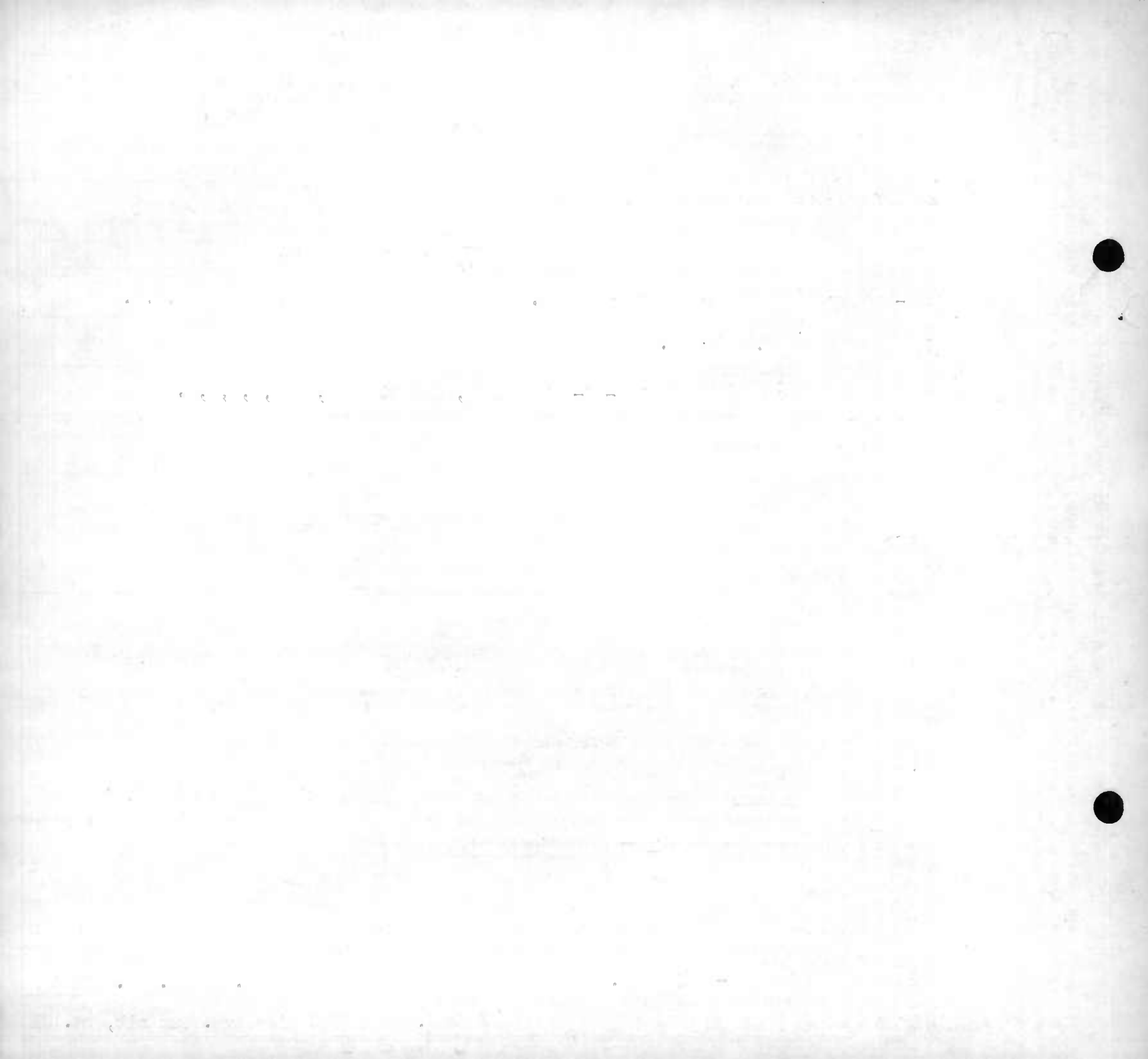
BIRTH NO. 65 6051		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 6051	
1. NAME OF DECEASED (Type or Print) <i>Behr, Cunigunda</i>				2. DATE AND HOUR OF DEATH <i>6/6/65 3:45 PM</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>North Charles General Hosp 2724 N Charles St</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore - Dundalk</i> D. STREET ADDRESS (If rural, give location) <i>8337 Bear Creek Drive</i>			
5. SEX <i>fe</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>11-16-88</i>	9. AGE (In years last birthday) <i>76</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>Baltimore md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Andrew Goeb</i>				14. MOTHER'S MAIDEN NAME <i>Anna Rietkner</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Patients Chart</i>			
18. <i>420.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>Coronary heart failure</i> DUE TO (B) <i>Acute myocardial infarction</i> DUE TO (C) <i>hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>5/20/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>No</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>5/22/65</i> 1965 to <i>6/6</i> 1965, that (I) (we) last saw the deceased alive on <i>6/6 at 3:45 PM</i> 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Ceselmo M. Celligro</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>6/6/65</i>			
23C. PHYSICIAN'S NAME (Type) <i>Atallah Gelpira</i>		23D. ADDRESS <i>1942 Cedar Lane Baltimore Md. 21222</i>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>June 10-1965</i>		24C. NAME of CEMETERY or CREMATORY <i>Sacred Heart of Jesus</i>		24D. LOCATION (City, town, or county) (State) <i>German Hill Rd. Dundalk, Md. 22</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>JOHN J. DUDA 7922 Wise Ave. Dundalk, 21222</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6052		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6052	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GEORGE H. HAHN		2. DATE AND HOUR OF DEATH JUNE 6, 1965 12:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL BALTIMORE, MARYLAND - 21201			A. STATE MARYLAND B. COUNTY Baltimore		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE - 21219 53-00			D. STREET ADDRESS (If rural, give location) 2119 LODGE FARM ROAD		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 7/14/06	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed		10B. KIND OF BUSINESS OR INDUSTRY Cord Equipment Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Jacob H. Hahn Sr.		
14. MOTHER'S MAIDEN NAME Ida Hodges			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) No No		
16. SOCIAL SECURITY NO. 372-24-2373			17. INFORMANT Wife, Janett Hahn, # 4,a,b,c,d.		
18. 463X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) PULMONARY EMBOLUS DUE TO (B) THROMBOPHLEBITIS, (C) LEG DUE TO (C) _____		
INTERVAL BETWEEN ONSET AND DEATH ? ?			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/28 1965 to 6/6 1965, that (I) (we) lost saw the deceased alive on 6/6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Martin C. Shargel M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED June 6, 1965	
23C. PHYSICIAN'S NAME (Type) MARTIN C. SHARGEL M.D.				23D. ADDRESS UNIVERSITY HOSPITAL, BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 17-1965		24C. NAME of CEMETERY or CREMATORY Mt. Carmel	
24D. LOCATION (City, town, or county) (State) O'Donnell St. Balto. Md. 21224		25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS JOHN J. DUDA 7922 Wise Ave. Dundalk, Md. 21222			



FUNERAL DIRECTOR: IMPORTANT

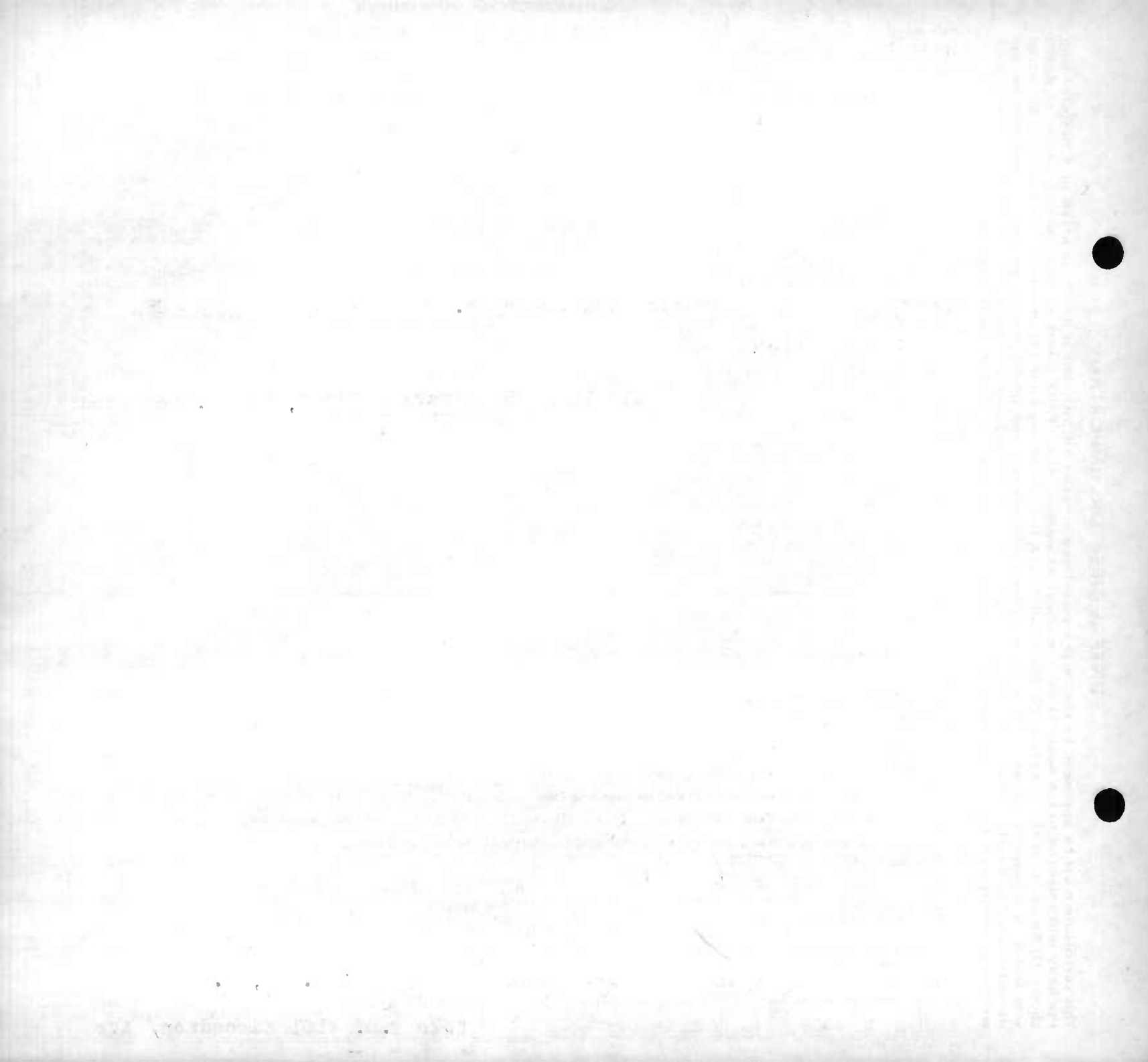
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 3		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6053	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>Kraushofer, Elizabeth</i>			2. DATE AND HOUR OF DEATH <i>6-7-65 12³⁰ P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Bon Secours Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>DALTIMORE COUNTY</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Lansdowne 27</i> D. STREET ADDRESS (If rural, give location) <i>220 Hazel Ave</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED <i>WIDOW</i>	8. DATE OF BIRTH <i>4-20-1890</i>	9. AGE (In years last birthday) <i>75</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Austria</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>Kolleck, Stephen</i>		
14. MOTHER'S MAIDEN NAME <i>Elizabeth-----</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <i>Balto. 23, Md. John L. Kraushofer, 220 Hazel Ave.</i>		
18. <i>260X1</i> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) <i>Coron. - Ischaemic?</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>16 hrs</i>
ANTECEDENT CAUSES			(B) <i>Acute Renal Shutdown</i> DUE TO		<i>16 hrs</i>
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) <i>Acute Pulmonary Edema</i>		<i>4 hrs</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>June 7, 1965</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>None</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 6, 1965</i> to <i>June 7, 1965</i> , that (I) (we) last saw the deceased alive on <i>June 7, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Zenaida C. Palad</i>				23B. DATE SIGNED <i>June 7, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>ZENALIDA C. PALAD</i>				23D. ADDRESS <i>Bon Secours Hosp. & Pulaski St. (Balto 23 Md)</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>June 11/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Loudon Park</i>	
24D. LOCATION <i>Baltimore 29, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 9 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>		25C. FUNERAL DIRECTOR <i>Witzke F.D. 4101 Edmondson Ave</i>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 6054					65 6054				
BIRTH NO. (4)					REGISTERED NO.				
1. NAME OF DECEASED (Type or Print) MRS. CHRISTINE A. KAPRAUN					2. DATE AND HOUR OF DEATH JUNE 8, 1965 4:15 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 20-08 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 29 D. STREET ADDRESS (If rural, give location) 20 S. Augusta Avenue				
5. SEX FE	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1/12/89	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10B. KIND OF BUSINESS OR INDUSTRY Arundel Ice Cream Co. Maryland			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Hohman					14. MOTHER'S MAIDEN NAME Hollomeyer				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 213 14 5905	17. INFORMANT (Son) Edward Kapraun			ADDRESS 114 N. Beechwood Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 260X I					CAUSE OF DEATH (A) Cardio-Pulmonary Failure DUE TO (B) Cardiac Failure DUE TO (C) Diabetes Mellitus				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from April 30 1965 to June 8 1965 , that (I) (we) last saw the deceased alive on 8 June 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Jan R. d. Lem, Jr.					M.D.	Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED June 8, 1965
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.				
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/11/65		24C. NAME of CEMETERY or CREMATORY New Cathedral			24D. LOCATION (City, town, or county) (State) Balto. 29, Md.		
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR W. tzke F.D.			ADDRESS 4101 Edmondson Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 6055		Registered No. 65 6055	
BIRTH NO.		65 6055		CERTIFICATE OF DEATH			
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) LOU TIFFANY MASON				2. DATE AND HOUR OF DEATH JUNE 6, 1965 900 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
UNIVERSITY HOSPITAL		BALTIMORE, MARYLAND - 21201		MARYLAND		Balto	
5. SEX F				6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow W	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 2/25/84		9. AGE (In years last birthday) 81	
H.W.		Own Home		11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ----- Tiffany				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Wm.S. Mason (Son) Winnsboro, S.C.			
18. 199.2.1		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) METASTATIC CARCINOMA DUE TO PRIMARY LESION UNKNOWN				2	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO					
		(C)					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/21 19 65 to 6/6 19 65 , that (I) (we) last saw the deceased alive on 6/6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Martin C. Shargel M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED JUNE 6, 1965	
23C. PHYSICIAN'S NAME (Type) MARTIN C. SHARGEL M.D.				23D. ADDRESS UNIVERSITY HOSPITAL, BALTO., MD-21201			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 6/7/65		24C. NAME of CEMETERY or CREMATORY Winnsboro, S.C.		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Falek		25C. FUNERAL DIRECTOR W. Itzke		ADDRESS F.D. 4101 Edmondson Ave	

1.

65 6056 BALTIMORE CITY HEALTH DEPARTMENT 65 6056 C
 BIRTH NO. 5430776 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

J.

VEYNA WILLIAMSON

2. DATE AND HOUR PRONOUNCED DEAD

6-7-65

6: 30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Ellicott City

D. STREET ADDRESS (If rural, give location)

23 Oakes Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)Single ~~marry~~

8. DATE OF BIRTH

Oct. 14, 1959

9. AGE (In years
last birthday)

5

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Reyna Williamson

14. MOTHER'S MAIDEN NAME

Violet Marlow

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Reyna Williamson, 23 Oakes Road, Ellicott City, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Interstitial myocarditis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

6-7-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

June 10/65

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

1 City, town, or county

1 State

Dublin, Ga.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 9 1965

Robert S. Fisher

Witzke F.D. 4101 Edmondson Ave

VALLEY

TRUCK

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Orlen I. Wahl

2. DATE AND HOUR OF DEATH

6-6-1965

1:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Dundalk

D. STREET ADDRESS (If rural, give location)

2331 Searles Road

21222

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

8-11-22

9. AGE (In years
last birthday)

42

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Barber,

Poplar Place Barber Shop

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George O. Wahl

14. MOTHER'S MAIDEN NAME

Susan Pyle

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

Yes, Army WW II, 1943-46

16. SOCIAL
SECURITY NO.

216-18-1491

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Probably Perforated Ulcer

48 Hours

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A)
DUE TO

ANTECEDENT CAUSES

(B)
DUE TODISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At
Work ☐Not While
At Work ☐22. I certify that (I) (this hospital) attended the deceased from 6-6-19 65 to 6-6-19 65,
that (I) (we) last saw the deceased alive on 6-6-19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6-6-1965

23C. PHYSICIAN'S
NAME (Type)

Dr. Donald Baltzan

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

June 9-1965

24C. NAME of CEMETERY or CREMATORY

Baltimore National

24D. LOCATION

(City, town, or county)

(State)

Frederick Rd. Catonsville, Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 9 1965

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

John J. Duda, 7922 Wise Ave. Dundalk, Md. 21222

8/2/65 - Reported Pepler Alcor - information from
Baltimore City Hosp. filed in Room of Broasthorne
American Relief Co.

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Albert E. Conner, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

June 7, 1965

8:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

Dundalk

D. STREET ADDRESS (If rural, give location)

1954 Haselmere Road

21222

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

May 29, 1946

9. AGE (in years
last birthday)

19

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Bethlehem Steel Co.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Albert E. Conner, Sr.

14. MOTHER'S MAIDEN NAME

Bertha Neill

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-44-9569

17. INFORMANT

ADDRESS

Parents, Albert & Bertha Conner, #4, a, b, c, d.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral injury
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

3 6-3-65

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Head injury

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)O'Donnell St. Bridge 1040' E. of Conkling
Street21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

6 2 65 11:15

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver in auto-auto collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-8-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

June 11, 1965

23C. NAME OF CEMETERY or CREMATORY

Oak Lawn

23D. LOCATION

(City, town, or county)

(State)

Eastern Ave. Bal. Co. Md. 21222

24A. DATE REC'D BY HEALTH DEPT.

JUN 9 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

JOHN J. DUDA, 7922 Wise Ave. Bal. Co. Md. 22

VALLEY FORD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 6059		REGISTERED NO. 65 6059	
CERTIFICATE OF DEATH				1. NAME OF DECEASED (Type or Print) HAROLD L. LAMBERT		2. DATE AND HOUR OF DEATH JUNE 7, 1965 11:45 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL BALTO. Md.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Dundalk 53-00 D. STREET ADDRESS (If rural, give location) 1965 Church Rd. 21222			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6-24-14	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel.		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ira Lambert				14. MOTHER'S MAIDEN NAME Inez Knight			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. 215-05-3791		17. INFORMANT Wife, Mrs. Anna Lambert, # 4, a, b, c, d.			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Gastro-Intestinal Hemorrhage (B) Pneumonia & Aneurysm (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH 5 days			
19A. DATE OF OPERATION 6/2/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/2/65 19 to 6/7/65 19 that (I) (we) last saw the deceased alive on 6/7/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.							
23A. SIGNATURE Angel H. Roque M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/8/65	
23C. PHYSICIAN'S NAME (Type) ANGEL H. ROQUE M.D.				23D. ADDRESS LUTHERAN HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 11-1965		24C. NAME of CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Trumps Mill Rd. Bal. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Fickler		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, 21222			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 6060		65 6060	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		LEON ALEXANDER Fox, M.D.		2. DATE AND HOUR OF DEATH June 5 1965 10 ¹⁹ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.			
UNIVERSITY Hospital Baltimore, Md.		B. COUNTY 12-01			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3601 GREENWAY (CARROLLTON Apt #609)			
5. SEX Male	6. RACE Cau	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/2/91	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ala.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME David Fox		14. MOTHER'S MAIDEN NAME Theresa Von Stukenberg			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Retired (General)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 00301 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Pericarditis & Pleuritis, TBC (Eug) (B) DUE TO Arteriosclerosis, generalized (C) Multiple Diverticuli of Urinary Bladder & Chronic Cystitis → 50 yrs.		INTERVAL BETWEEN ONSET AND DEATH 5 mos	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 4/25 1965 to 6/5 1965, that (I) (we) last saw the deceased alive on 6/5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald T. Lewers		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/5/65	
23C. PHYSICIAN'S NAME (Type) DONALD T. LEWERS		23D. ADDRESS University Hospital, Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8 Jun 1965	24C. NAME OF CEMETERY or CREMATORY Arlington National Cemetery		24D. LOCATION (City, town, or county) (State) Fort Myer, Virginia	
25A. DATE REC'D BY HEALTH DEPT. JUN 9 1965		25B. NAME OF REGISTRAR Robert E. Jankowski		25C. FUNERAL DIRECTOR Rinaldi Funeral Home, Inc. 7400 Ga. Ave. N.W. Wash., D.C.	

1		65 6061		BALTIMORE CITY HEALTH DEPARTMENT		65 6061	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD			
		GEORGE W. LA FLAME		June 8, 1965		5:00 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY	
		Maryland					
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
43 South Baltimore General Hospital				Baltimore # 18 12-06			
D. STREET ADDRESS (If rural, give location)		2718 N. Howard Street					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
Male	White	Married	March 21, 1908	57			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Truck Driver		Geo. Rosen Co.		West Virginia		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
George W. LaFlame		Nettie Anderson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		217-05-4111		Mrs. Edna L. LaFlame		(Same)	
18. 422.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Arteriosclerotic Cardiovascular Disease. DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO					
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Cirrhosis.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes		Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		Charles S. Petty		M.D.		DATE SIGNED	
EXAMINER'S NAME (Type)		Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		6/9/65	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		6/12/65		Moreland Memorial Cem.		Baltimore, Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
JUN 9 1965		Robert E. Fadden		Leonard J. Ruck Inc. Balto. 14 Md.			

WILLIAM W. FERGUSON

18

March 11, 1970

James E. Ferguson

27-01-0111 (see page 1. below)

[Handwritten signature]

William W. Ferguson

James E. Ferguson

James E. Ferguson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6062	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Hanline, Sarah C.</i>	
2. DATE AND HOUR OF DEATH <i>June 8 1965 5:30 A.M.</i>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND (If not in hospital or institution, give street address or location) <i>Md. General Hospital.</i>			
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>27-03</i>		5. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #14</i>			
6. STREET ADDRESS (If rural, give location) <i>2906 E. Strathmore Ave.</i>		7. SEX <i>F</i> 8. RACE <i>W</i> 9. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>			
10. AGE (In years last birthday) <i>85</i>		11. DATE OF BIRTH <i>May 29/80</i>		12. If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore West Va.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Henry Stemple (dec.)</i>		14. MOTHER'S MAIDEN NAME <i>Loma Lemhart (Dec.)</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Nola Burger</i>	
18. <i>4201 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Acute myocardial infarction</i>		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>4-24 hrs</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Anteriosclerotic cardiovascular disease</i>		(B) DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>Yes</i>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>May 31 1965</i> to <i>June 8 1965</i> , that (I) (we) lost saw the deceased alive on <i>5:00 AM 5/30/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Kyoungho M. Cynn</i>				23B. DATE SIGNED <i>6-8-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Kyoungho M. Cynn</i>				23D. ADDRESS <i>Md. General Hospital.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/11/65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Cumberland, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 9 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Parker</i>		25C. FUNERAL DIRECTOR <i>L. F. Ruck, Inc. Balto 14 Md.</i>			

VS 153 + letter from Md. Gen'l. Asst.
7-12-65 MN-

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RACHEL K. SCHUM

2. DATE AND HOUR PRONOUNCED DEAD

June 8, 1965

2:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6413 Ridgeview Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec. 6, 1915.

9. AGE (In years
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Daniel D. Stotler

14. MOTHER'S MAIDEN NAME

Bertha Stottlemeyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-09-0702

17. INFORMANT

Mr. Alfred J. Schum

ADDRESS

(Same)

18.

E979X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Asphyxia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Plastic Bag Over Head and Face.
DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

6413 Ridgeview Road

21D. TIME
OF INJURY
(APPROX.)

6

8

'65

P

m.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

X

21F. HOW DID INJURY OCCUR?

Plastic bag over head.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/9/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/11/65.

23C. NAME of CEMETERY or CREMATORY

Rest Haven Cemetery

23D. LOCATION

(City, town, or county)

Hagerstown, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 9 1965

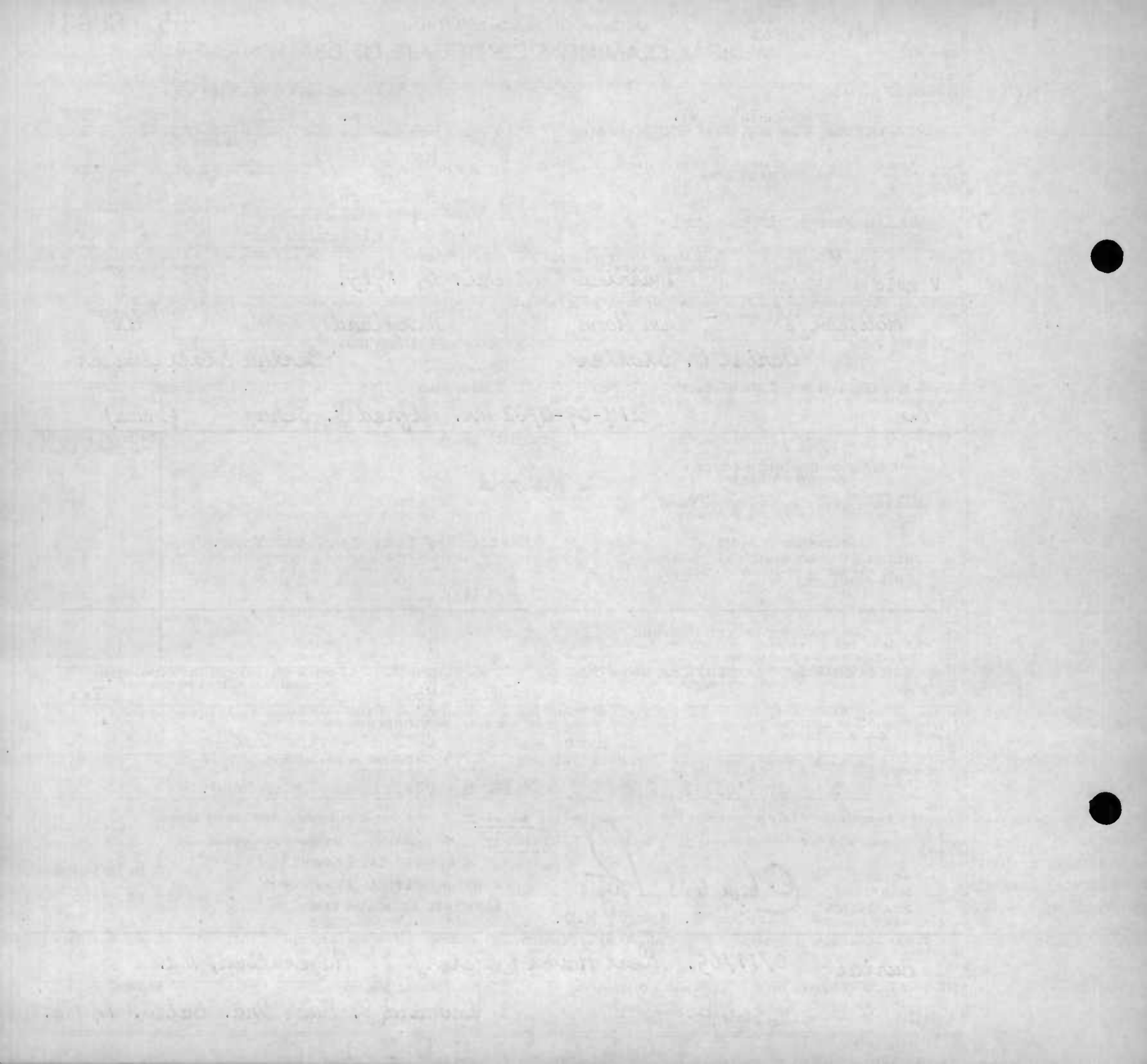
24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto. 14 Md.

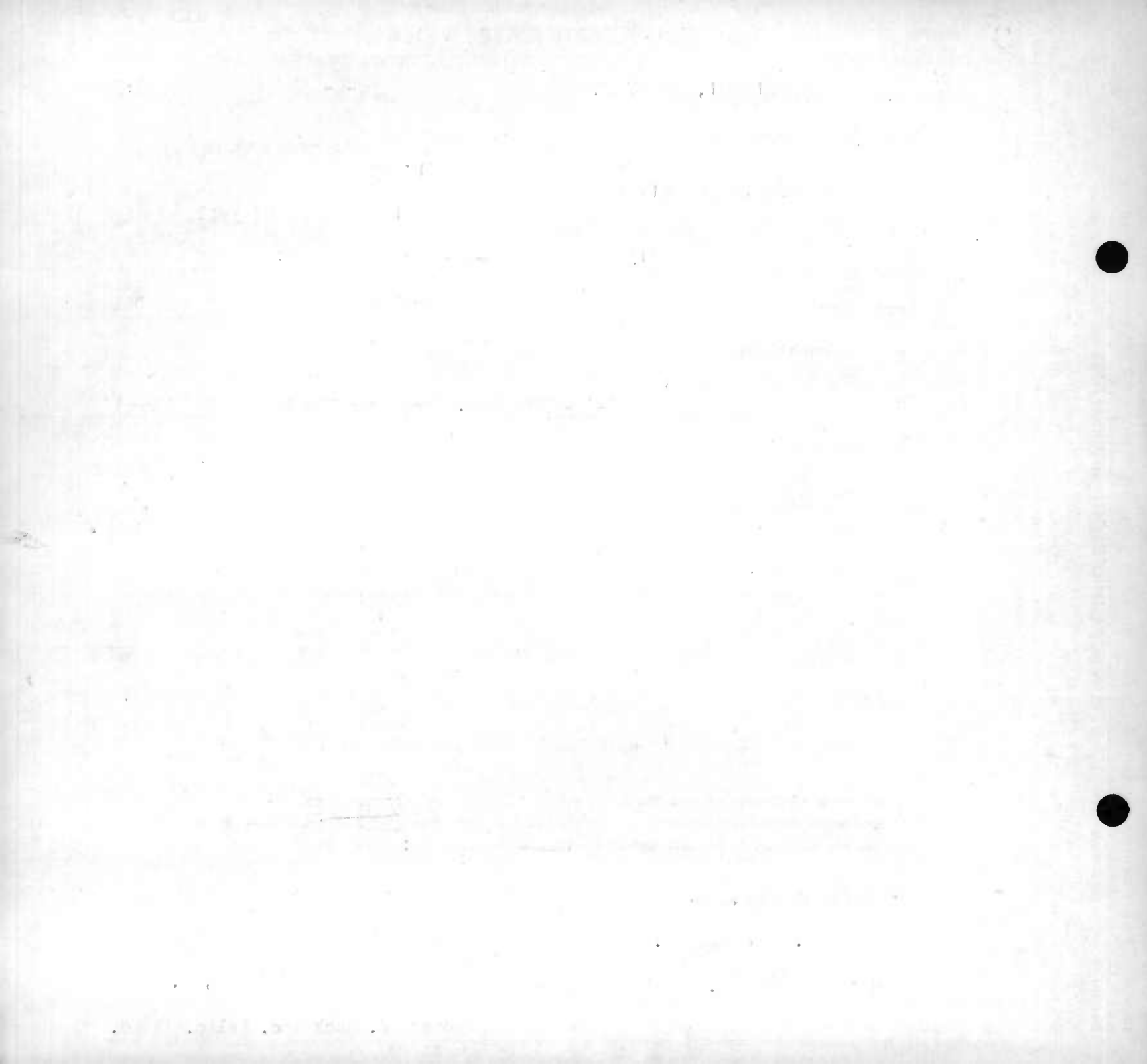
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				65 6064		65 6064	
BIRTH NO.				65 6064		Registered No.	
M.E. CASE NO.				65 6064		65 6064	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
MECHLINSKI, HENRY J.				6-8-65 12:30AM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				5532 MIDWOOD AVENUE #12			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
M	W	MARRIED	1-26-04	61			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Bartender			Maryland		USA		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOSEPH Mechlinski				MARY ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		213-10-4394		Mrs. Norma Mechlinski		(Same)	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) acute renal failure 4 da			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) multiple myeloma 2 mo.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from May 19 65 to June 8, 19 65, that (I) last saw the deceased alive on June 8, 19 65 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Kenneth E. Quickel Jr.						June 8, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
KENNETH E. QUICKEL JR.		Johns Hopkins Hosp.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/11/65		Holy Redeemer Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 9 1965		E. J. J.		Leonard J. Ruck Inc. Balto. 14 Md.			



FUNERAL DIRECTOR: IMPORTANT

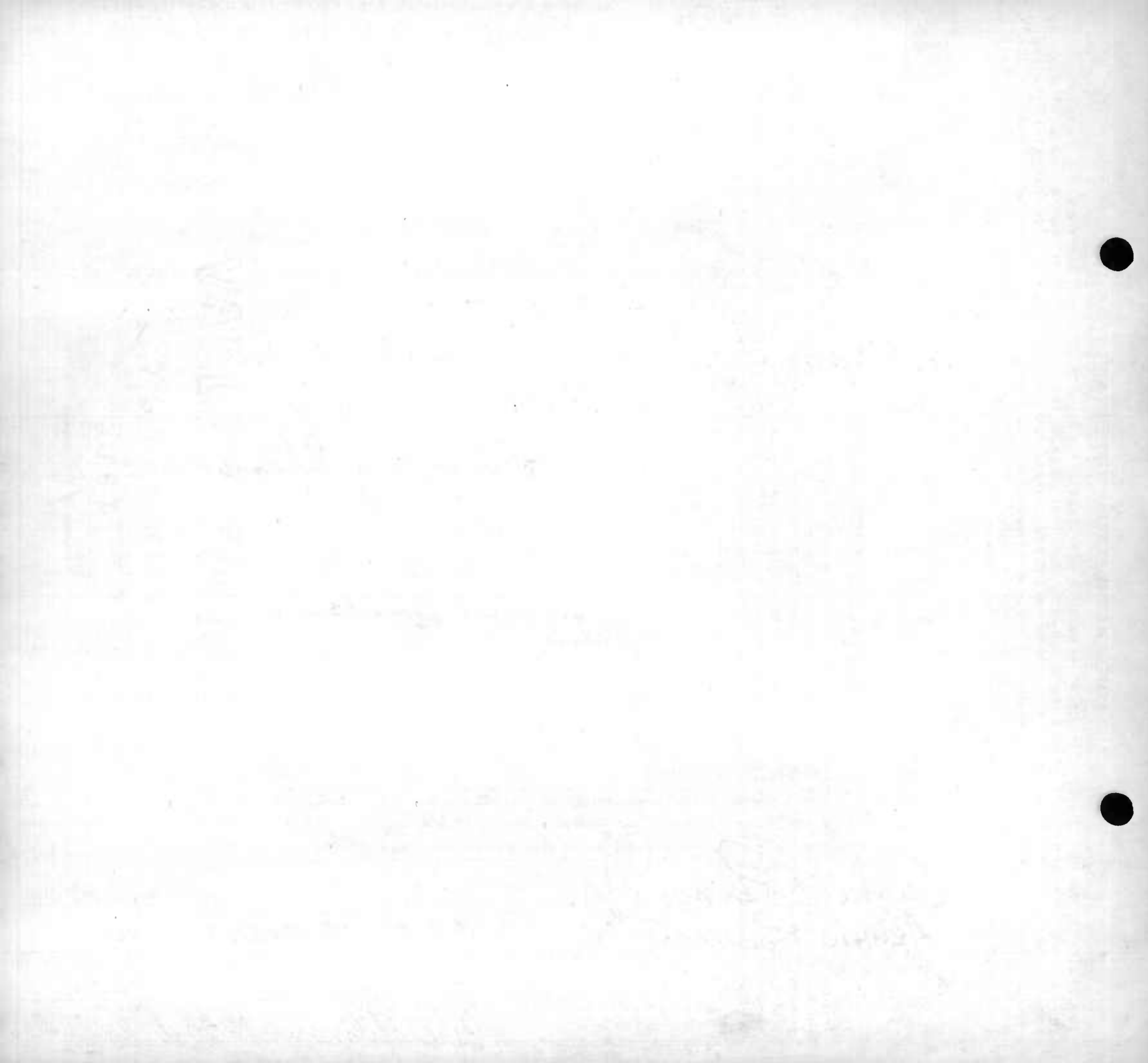
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6065	
BIRTH NO. 65 6065		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charles Kellam		2. DATE AND HOUR OF DEATH June 8, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION House in The Pines Nursing Home		A. STATE Maryland 8. COUNTY 17-02			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1151 Myrtle Ave			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Dec 16, 1891	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butler		10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family		11. BIRTHPLACE (State or foreign country) Accomac Co. Va.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Gertrude Bell - Bronx, N.Y.	
18. 422.1		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Acute Pulmonary Infection			Acute
ANTECEDENT CAUSES		DUE TO Hypertensive Cardiovascular Disease			10 years
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO Pulmonary Edema & Congestive Heart Failure			1 yr.
		& generalized edema			6 mo.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Generalized Atherosclerosis & Scleritis			10 yrs.
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 1956 19 to June 8 19 56 , that (I) (we) last saw the deceased alive on June 8, 1956 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. William Primoloff				23B. DATE SIGNED June 9, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. H. William Primoloff				23D. ADDRESS Eisenstein Apartments	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/65		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Ceme	
24D. LOCATION (City, town, or county) (State) Balto. Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 10 1965			
25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Earl Gibson - 1827 W. North Ave			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

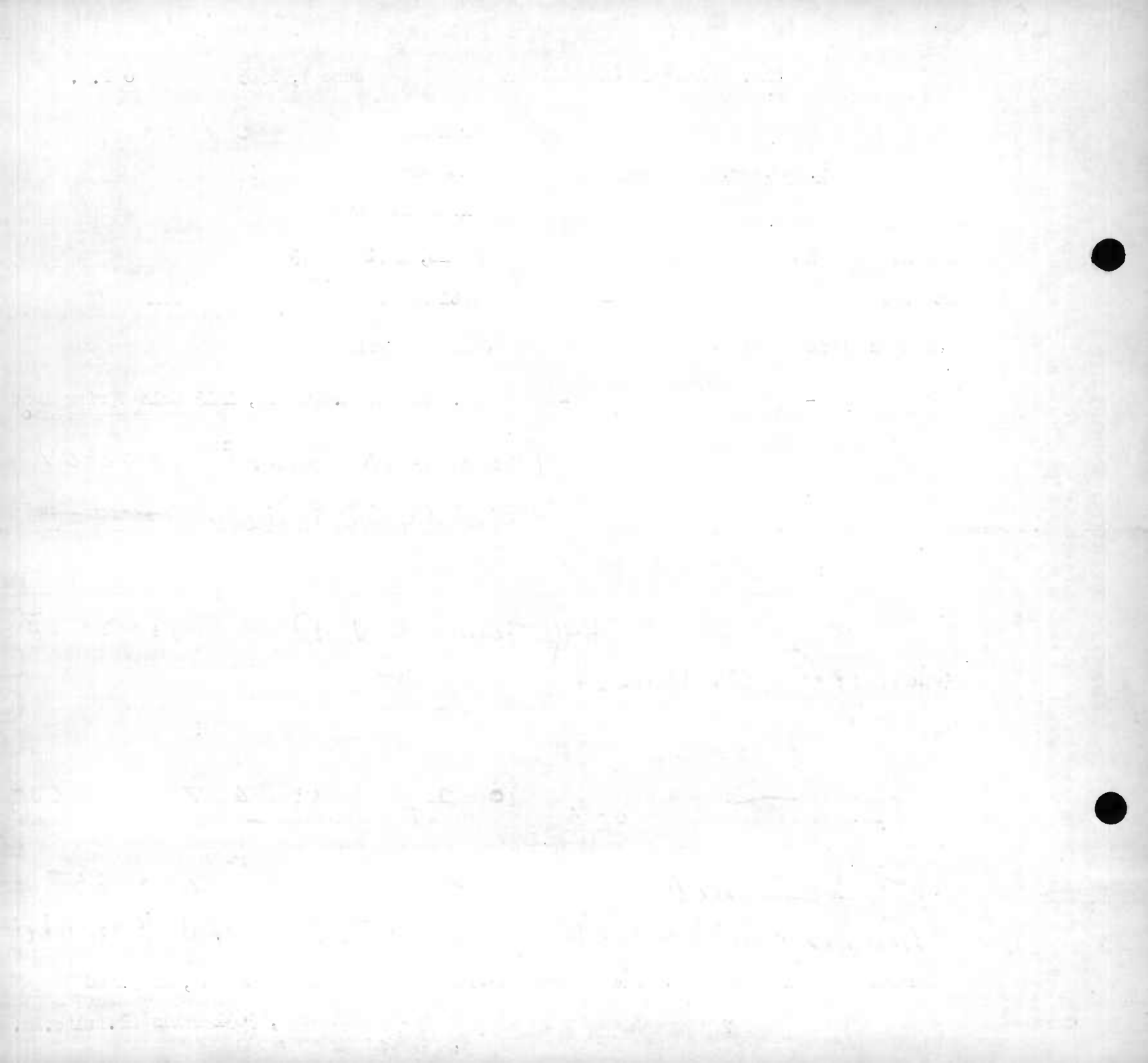
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 6066		65 6066			
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Austin Sydnor			June 7, 1965 3:45p M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217			A. STATE Maryland		
			B. COUNTY 18-02		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
Baltimore			303 N. Carrollton Avenue		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	Negro	Married	August 5, 1890	74	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Retired			Virginia		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William Sydnor			Sarah Newton		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
no			216-07-6561		Aileen Sydnor-wife
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Pulmonary Edema		
			(A) DUE TO		
			(B) DUE TO		
DISEASE OR CONDITION CAUSING IT.			(C) DUE TO		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
2			Perforated Duodenal Ulcer, Peritonitis		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
yes			yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
<input type="checkbox"/>			(If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)			21E. HOW DID INJURY OCCUR?		
(Month) (Day) (Year) (Hour)			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from April 30, 1965 to June 7, 1965 1965, that (I) (we) last saw the deceased alive on June 7, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Arlene Robinson, Jr.			June 8, 1965		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
ARLENE ROBINSON, JR.			503 N. FREMONT AVE		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		6/11/65		Crown Hill Park Laurel Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 10 1965		Robert E. Farber, M.D.		Earl Gilmore - 1827 W. North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

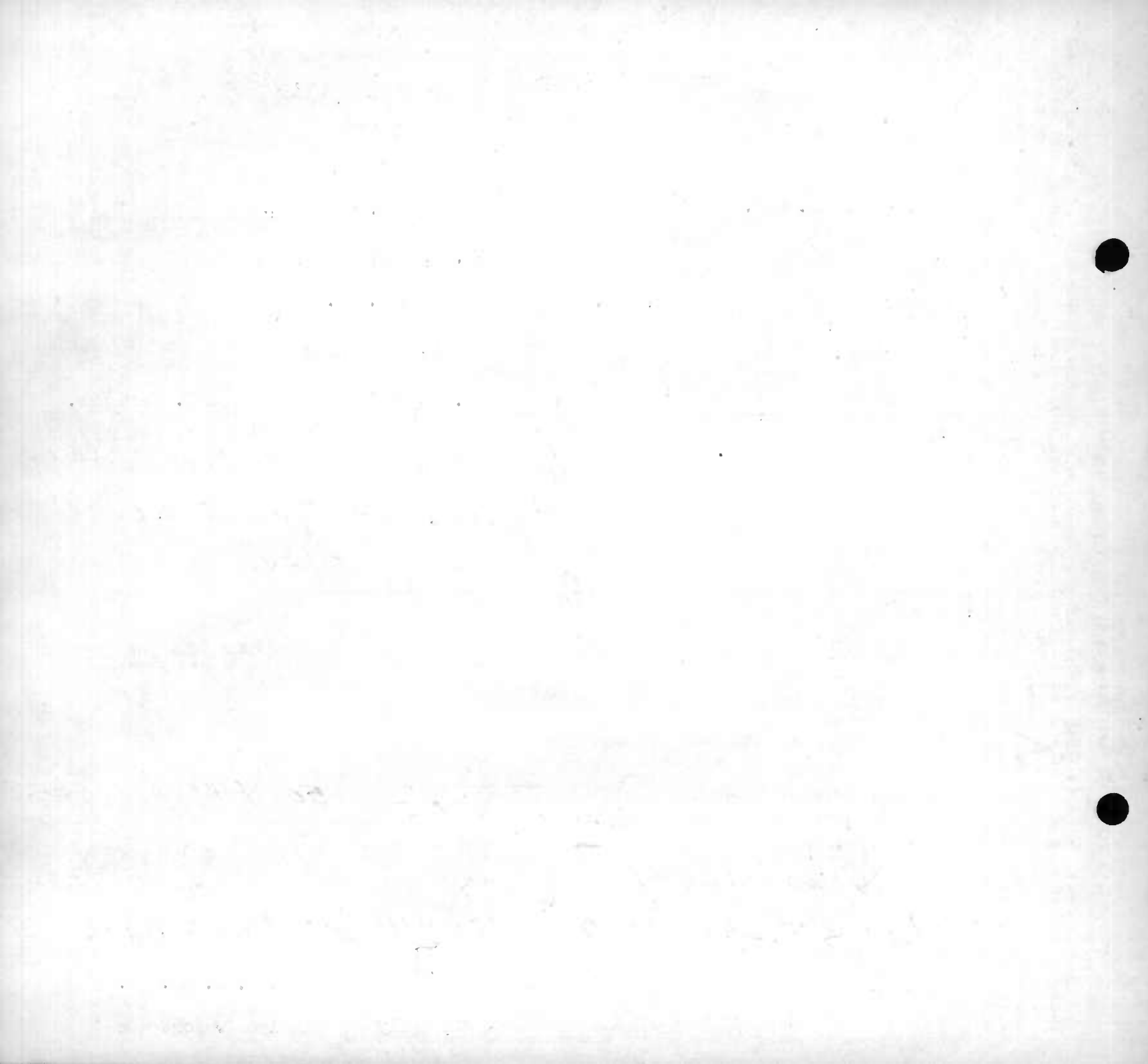
BIRTH NO. 65 6067				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6067	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MRS. ELIZABETH JANE YEAGER				2. DATE AND HOUR OF DEATH June 7, 1965 6 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 27-15	
1/49 Medfield Avenue				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 4118 Falls Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH May 16, 1892	9. AGE (In years last birthday) 73	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		11. BIRTHPLACE (State or foreign country) Scotland
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			10B. KIND OF BUSINESS OR INDUSTRY -		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John McRobbie				14. MOTHER'S MAIDEN NAME Jane Ann Gunn			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. -		17. INFORMANT Rev. Richard C. Hughes, 1413 Cold Spring Lane		
18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Carcinoma Breast</u> (B) <u>E. Hemolytic Metastasis</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH 12-30-64	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Hypertension CVD		10-2-58	
19A. DATE OF OPERATION Jan 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca Breast		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 10-3-65 to 6-7-65 that (I) (we) last saw the deceased alive on 6-6-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Shumanek				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-7-65	
23C. PHYSICIAN'S NAME (Type) Lawrence J. Shumanek				23D. ADDRESS 3711 Falls Rd Balto Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10 Jun 65		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1965		25B. NAME OF REGISTRAR Robert E. Falek		25C. FUNERAL DIRECTOR Burgee Funeral Home, 3631 Falls Rd. Balto. Md.		ADDRESS Burgee	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6068				BALTIMORE CITY HEALTH DEPARTMENT				65 6068			
M.E. CASE NO.				Registered No.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
Margaret M Miller				June 8, 1965				9 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE				B. COUNTY			
South Balto. Gen. Hospital				Maryland				24-02			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)							
				Baltimore							
				D. STREET ADDRESS (If rural, give location)							
				532 E. Fort Ave.							
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. Under 1 Yr. Months Days	
Female		White		Widow		Feb. 9, 1887		78			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Packer				Meat Co.				Balto. Md.		USA	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Joseph Klein						Annie Schmalzer					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No								Mrs. Catherine Sears 532 E. Fort Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)						CAUSE OF DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						Myocardial Infarction Hypertensive Cardiovascular disease					
INTERVAL BETWEEN ONSET AND DEATH						1 day					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 8, 1965 to June 8, 1965, that (I) (we) last saw the deceased alive on June 8, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.											
23A. SIGNATURE						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED			
Louis T. Lavy								June 9, 1965			
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS					
Louis T. Lavy M.D.						1844 W. North Ave Baltimore 17th					
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
Burial				6 12 65		Holy Cross				Brooklyn, A. A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
JUN 10 1965				Robert E. Farley M.D.				Mc Cully 130 E. Fort Ave			



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

MARTHA SUZANNE PERRY

2. DATE AND HOUR PRONOUNCED DEAD

6/4/65 9:40 a.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY A. A.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Annapolis 52-10

D. STREET ADDRESS (If rural, give location)

130 Dewey Drive

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

12-9-46

9. AGE (In years last birthday)

18

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

STUDENT

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

LEONARD C. PERRY

14. MOTHER'S MAIDEN NAME

Evelyn Peterson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Leonard C. Perry 130 Dewey Drive Annapolis, Md

18. E816.4.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia following Injury to the Brain.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Church Rd.- Arnold, Md.

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) (Minute)

5 31 65 10:30p

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

passenger in auto-auto collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

6/4/65

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

6-8-65

23C. NAME OF CEMETERY or CREMATORY

St James

23D. LOCATION (City, town, or county)

Tracy's Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 10 1965

24B. NAME OF REGISTRAR

Robert E. Faldut

24C. FUNERAL DIRECTOR

Hardesty Funeral Home 12 Ridge Ave Annapolis, Md

ADDRESS

WALTER JOHNSON

CERTIFICATE OF DEATH

Registered No. 65 6070

BIRTH NO.

65 6070

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Despina Teromonachos

2. DATE AND HOUR OF DEATH

6-7-1965

4:20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

404 South Macon Street 21224

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

10-20-1905

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Greece

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael Koufacko

14. MOTHER'S MAIDEN NAME

Anna Haritis

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. 4 20 11

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Myocardial Infarction

Instant

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A)
DUE TOArteriosclerotic Cerebral
Vascular Disease

Years

ANTECEDENT CAUSES

(B)
DUE TODISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

? Arrhythmia

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At ☐
WorkNot While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-6-1965 to 6-7-1965,
that (I) (we) last saw the deceased alive on 6-7-1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Alexander S. Townes

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

6-7-1965

23C. PHYSICIAN'S
NAME (Type)

Dr. Alexander S. Townes

23D. ADDRESS

M.D.

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/9/65

24C. NAME OF CEMETERY or CREMATORY

Greek Orthodox Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 10 1965

25B. NAME OF REGISTRAR

Robert E. Faldut

25C. FUNERAL DIRECTOR

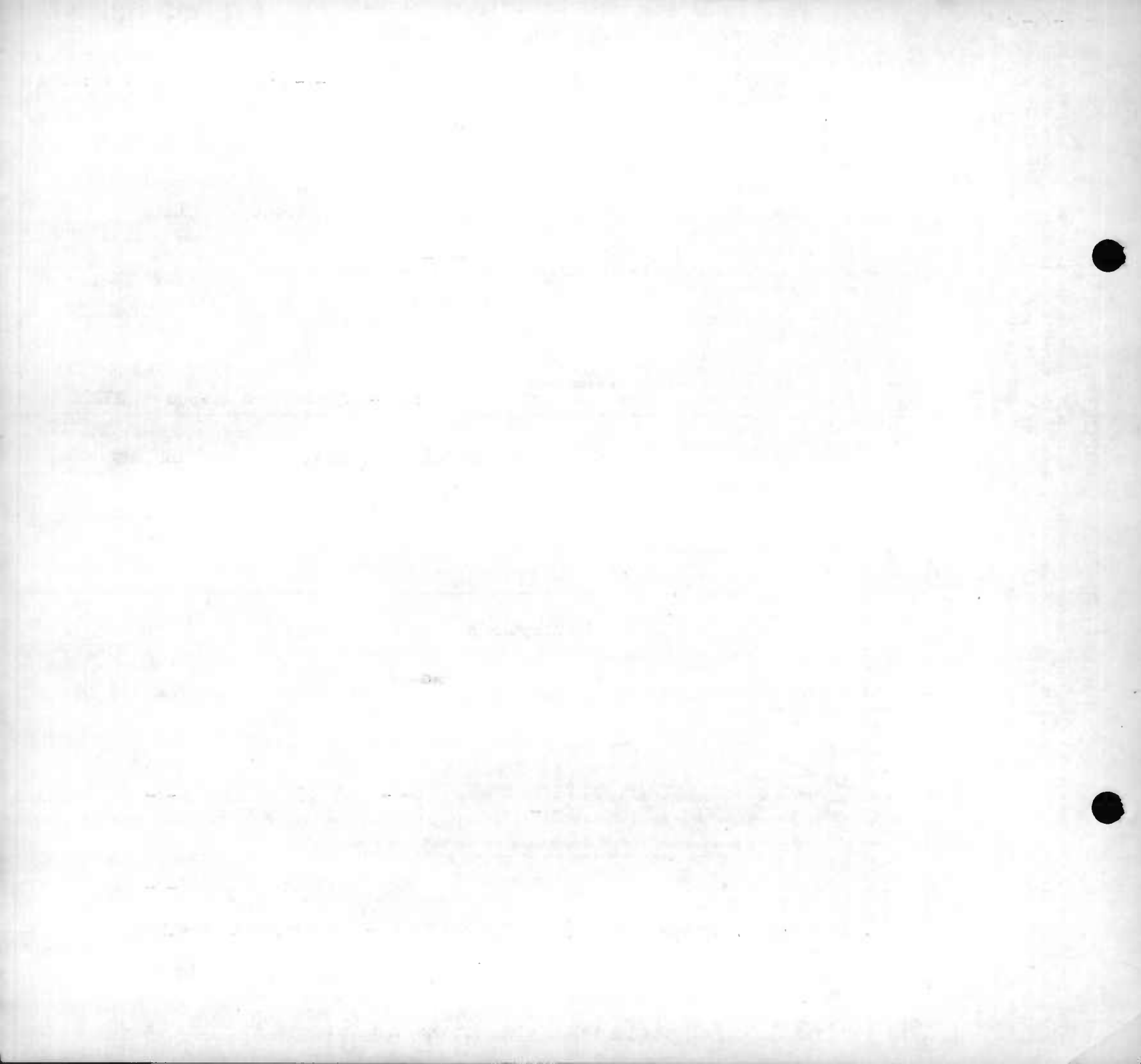
Nicholas T. Matthews

ADDRESS

3624 Eastern Ave, Baltimore, Md.

FUNERAL DIRECTOR: IMPORTANT

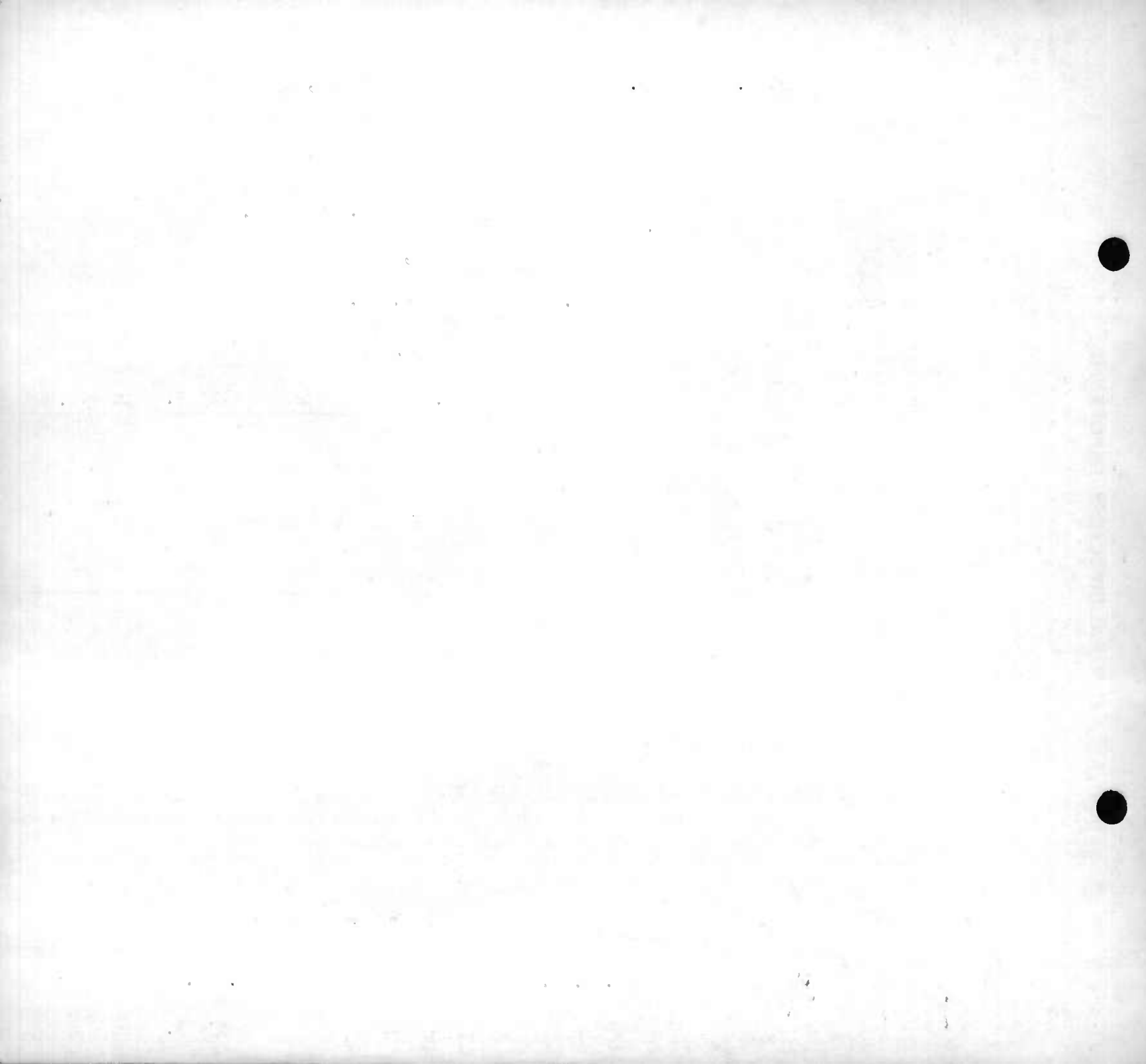
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

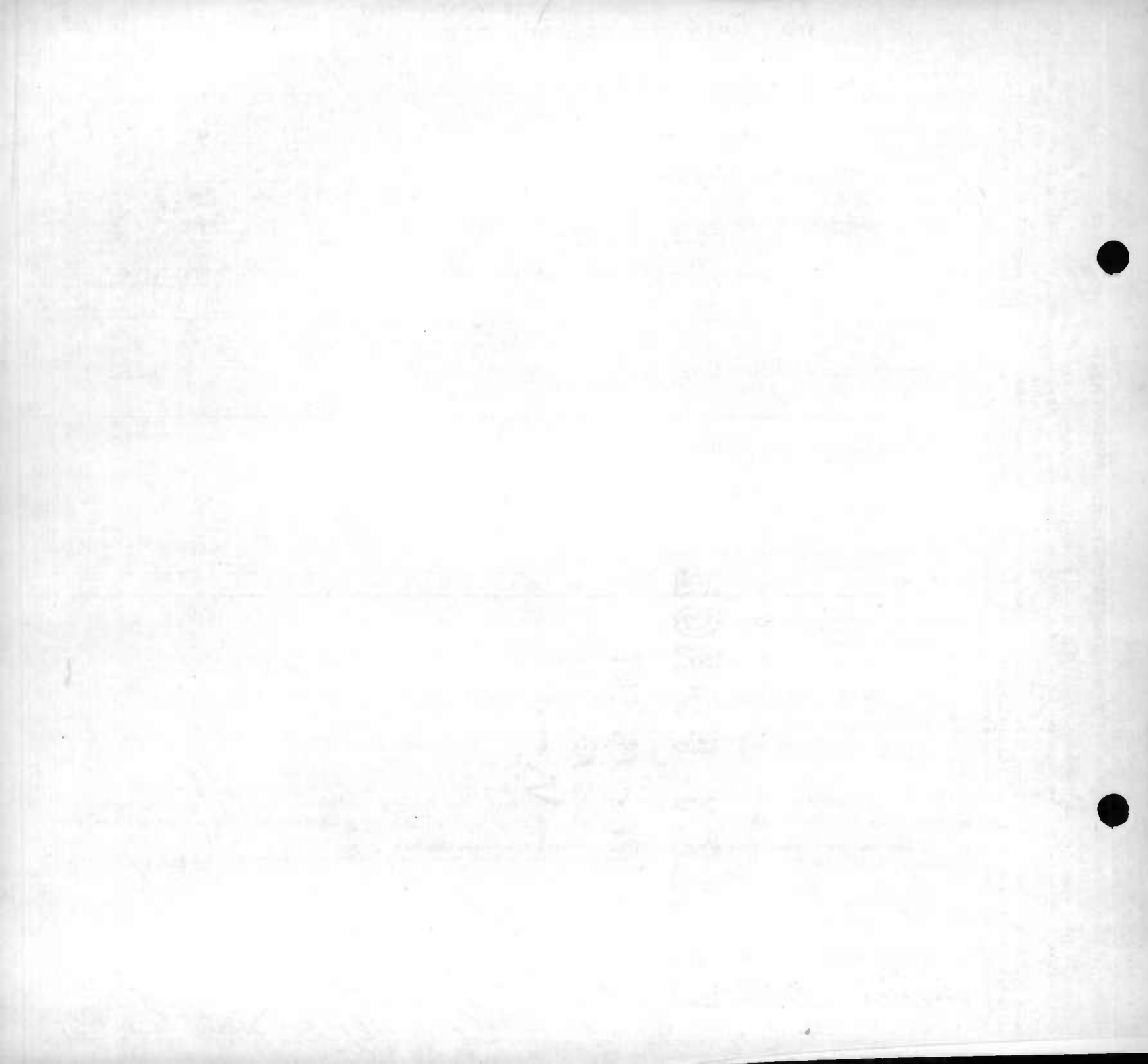
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6071	
BIRTH NO. 65 6071		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Robert H. Allen Sr.		2. DATE AND HOUR OF DEATH June 8, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) House In Pines Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 24-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 823 E. Fort Ave.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH March 10, 1886	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Glass Co.		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME William Allen		
14. MOTHER'S MAIDEN NAME Charlotte			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1		
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Clara Byrnes		
ADDRESS 823 E. Fort Ave.					
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Generalized Arteriosclerosis DUE TO (B) Diabetes Mellitus DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 4 yr. 7 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1958 to June 8, 1965 , that (I) (we) last saw the deceased alive on 6-8-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. C. Sollod				23B. DATE SIGNED 6-9-65	
23C. PHYSICIAN'S NAME (Type) A. C. SOLL OD				23D. ADDRESS 707 E. Fort Ave - 30	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6 11 65		24C. NAME of CEMETERY or CREMATORY Balto. U. S. National	
24D. LOCATION (City, town, or county) (State) Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Mc Cully	
ADDRESS 130 E. Fort Ave					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6072		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6072	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PALMER-WOLF ADA		2. DATE AND HOUR OF DEATH 6/9/65 5.05 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 2709		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL 827 LINDEN AVE BALTIMORE 1, MD		D. STREET ADDRESS (If rural, give location) 2017 HILLENWOOD RD.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8/8/01	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. W.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Wm. EVANS		14. MOTHER'S MAIDEN NAME ROSA SHIPLEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MARYLAND GEN. HOSP. 827 LINDEN AVE	
18. 420.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) ACUTE CORONARY INSUFFICIENCY DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/8/65 1965 to 6/9 1965, that (I) (we) last saw the deceased alive on 6/9/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Pietro Lortucci		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/9/65	
23C. PHYSICIAN'S NAME (Type) LASTRUCCI PIETRO		23D. ADDRESS M.D. MARYLAND GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/65		24C. NAME of CEMETERY or CREMATORY Morgan's Chapel Cem.	
24D. LOCATION (City, town, or county) (State) Hoodline, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS Connolly 300 Mac Ave. Balto. 21	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) A fracture of any kind; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6073				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6073	
1. NAME OF DECEASED (Type or Print) DOROTHY KOWALSKY				2. DATE AND HOUR OF DEATH 6/6/65 11:30 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) ROSEDALE D. STREET ADDRESS (If rural, give location) 7906 31ST. STREET			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED	8. DATE OF BIRTH 1-22-1897	9. AGE (In years last birthday) 67 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothing manuf.			10B. KIND OF BUSINESS OR INDUSTRY seamstress		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Bronzert				14. MOTHER'S MAIDEN NAME Stephanie Skruscha			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 218-12-2351		17. INFORMANT Steve Kowalsky ADDRESS 7906-31st St (G)		
18. 330X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) RUPTURED berry aneurysm of ant. central artery				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) ASCVD		INTERVAL BETWEEN ONSET AND DEATH 2 wks year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 6/6/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 5/29 19 65 to 6/6 19 65 , that (1) (we) last saw the deceased alive on 6/6 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W. Maddy				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/6/65	
23C. PHYSICIAN'S NAME (Type) DR. W. MADDREY.				23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-10-65		24C. NAME of CEMETERY or CREMATORY Holy Rosary		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Alfred H. Butler-1211 Chesaco Ave. 21206			

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W. H. H. H. H. H.

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FUNERAL DIRECTOR: IMPORTANT

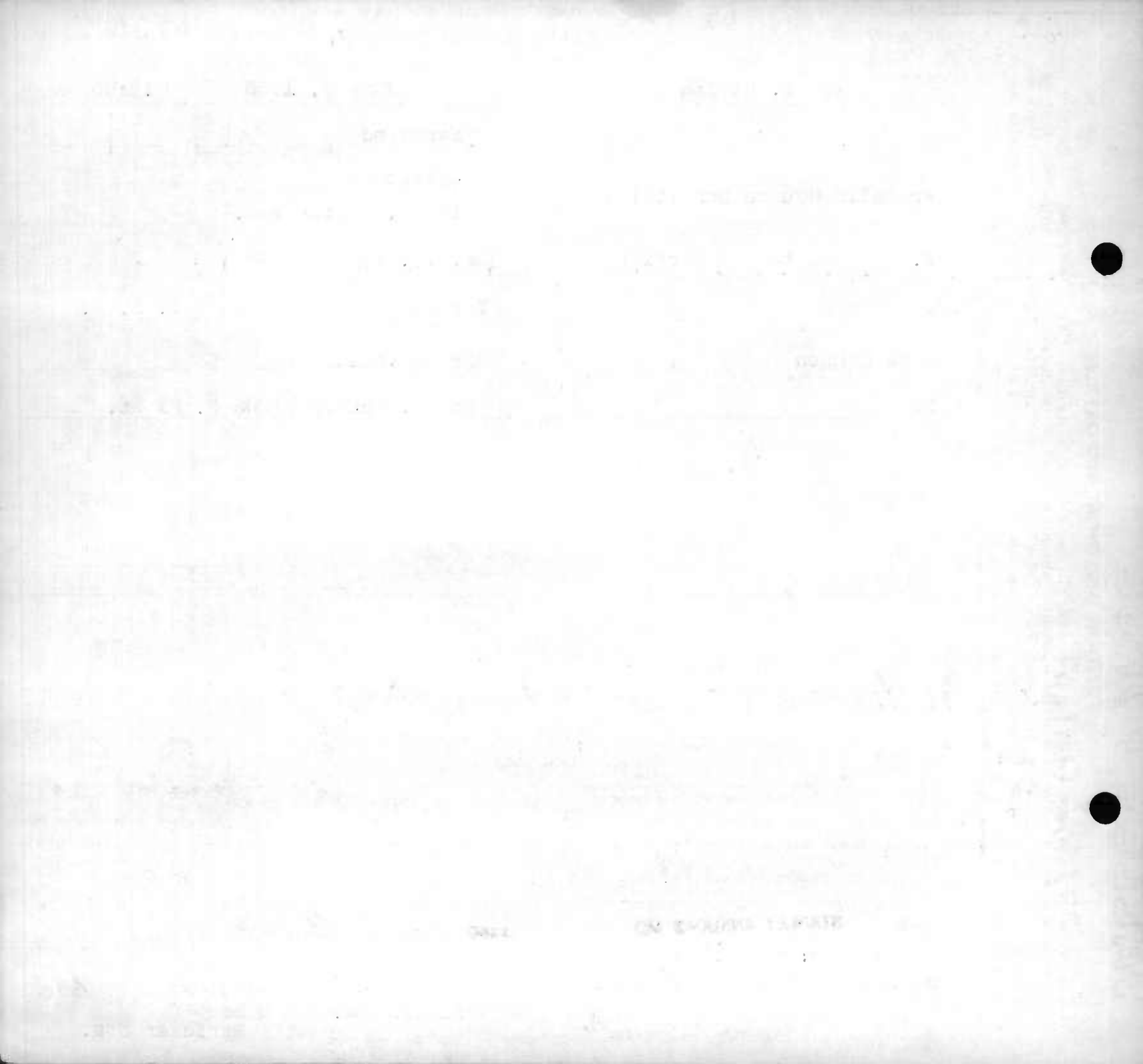
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
65 6074										Registered No. 65 6074	
BIRTH NO.											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <i>Macneal, James Walter, Jr.</i>						2. DATE AND HOUR OF DEATH <i>June 8, 1965</i> 2 ³⁵ _P M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i>						A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i>					
CITY OR TOWN (If outside city limits, write RURAL and give township)						D. STREET ADDRESS (If rural, give location)					
						<i>1326 Evering Ave - Zone 6</i>					
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i>		8. DATE OF BIRTH <i>Mar 20, 1901</i>		9. AGE (In years last birthday) <i>64</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maintenance</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Theater</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James W Macneal</i>						14. MOTHER'S MAIDEN NAME <i>Grace Ebert</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>U</i>				16. SOCIAL SECURITY NO. <i>BY-05-1625</i>		17. INFORMANT <i>J.W. Macneal - patient</i>				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH <i>Irreversible cardiac fibrillation</i> <i>Old coronary artery disease with atherosclerosis</i> <i>Acute cholecystitis</i> <i>Old duodenal ulcer</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hrs</i> <i>8 years</i> <i>1 wk</i>	
MEDICAL CERTIFICATION											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Old duodenal ulcer</i>											
19A. DATE OF OPERATION <i>6-8-65</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Acute Cholecystitis</i>				20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>June 1</i> 19 <i>65</i> to <i>June 8</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>June 8</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>S.G. Sullivan</i>								M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6-8-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>S.G. Sullivan</i>						23D. ADDRESS <i>1129 St Paul St Baltimore 2 Md.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/11/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Gardens of Faith Cemetery</i>				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 10 1965</i>				25B. NAME OF REGISTRAR <i>Robert E. Fink</i>				25C. FUNERAL DIRECTOR <i>Reginald P. Seitz 5209 York Road Seitz Funeral Home Balto. Md. 2 1212</i>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

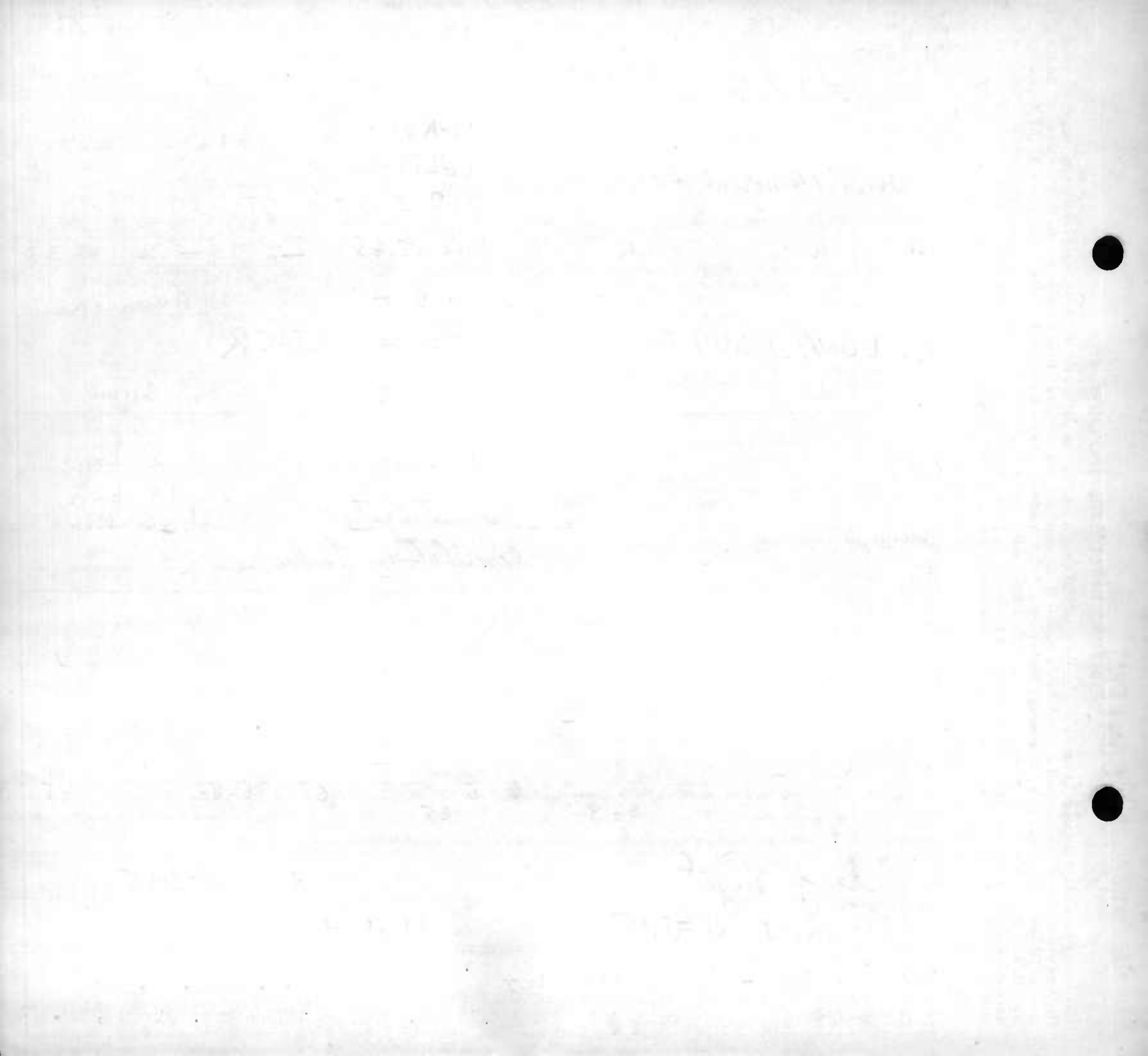
BIRTH NO. 65 6075				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6075	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) IDA L. RITTER			
2. DATE AND HOUR OF DEATH June 8, 1965 12:05 A.M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland 19-04				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 110 S. Fulton Ave.			
5. SEX F.		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Aug. 19, 1900	
9. AGE (In years last birthday) 64		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Mark Cannon			
14. MOTHER'S MAIDEN NAME Mary Reynolds				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS Anna C. Ackers 1903 E. 31 St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Pulmonary edema (B) DUE TO Acute heart failure (C) C.S.P.V.D. Hypertension			
INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1964 to June 8, 1965, that (I) (we) last saw the deceased alive on June 8, 1965, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stanley Ankudas MD				23B. DATE SIGNED 6.8.65			
23C. PHYSICIAN'S NAME (Type) STANLEY ANKUDAS MD				23D. ADDRESS 1160 1802 W. Beeth & Beeth 3			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/11/65		24C. NAME of CEMETERY or CREMATORY Western Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR Walters Funeral Home		ADDRESS Pratt & Stricker Sts.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65-13697 65 6076		CERTIFICATE OF DEATH				Registered No. 65 6076			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby boy SUTTON				2. DATE AND HOUR OF DEATH June - 8 - 1965 9-30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 12-02				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp.		D. STREET ADDRESS (If rural, give location) 319 E. 30th St.							
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH June - 5 - 65	9. AGE (In years lost birthday) —	If Under 1 Yr. Months Days Hours Min. — 2 17 30		If Under 24 Hrs. Min. —	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U-S-A		12. CITIZEN OF WHAT COUNTRY? America			
13. FATHER'S NAME Mr. DONALD SUTTON				14. MOTHER'S MAIDEN NAME JANE STACK					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Parent,		ADDRESS Same			
18. 723.571 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) sclerema DUE TO (B) Prematurity DUE TO (C) circulatory failure		INTERVAL BETWEEN ONSET AND DEATH 2 Days 17 hours 30 Min			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6-5-1965 to 6-8-1965, that (I) (we) last saw the deceased alive on 6-8-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Irak Nejat				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-8-65			
23C. PHYSICIAN'S NAME (Type) IRAJ NEJAT				23D. ADDRESS C.M.H.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 9-1965		24C. NAME of CEMETERY or CREMATORY Swart's Cemetery		24D. LOCATION (City, town, or county) (State) O'DONNELL ST. BALTO. MD. 21224			
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1965		25B. NAME OF REGISTRAR Robert E. Farkes		25C. FUNERAL DIRECTOR ADDRESS JOHN J. DUDA 7922 Wise Ave. Dundalk, Md. 22					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6077				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6077	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) AGRESTA, FLORA ✓				2. DATE AND HOUR OF DEATH 6-5-65 9:20 AM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				A. STATE MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 2109 EAST BALTIMORE STREET			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 5-13-94	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNK		10B. KIND OF BUSINESS OR INDUSTRY UNK		11. BIRTHPLACE (State or foreign country) BLUE EARTH MINN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISADORE HIMBER				14. MOTHER'S MAIDEN NAME ODELLA MELZER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 167-18-2042A		17. INFORMANT ADDRESS ST MICHAELS CHURCH 7 S WOLFE ST			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO Acute papillary necrosis (L) Kidney - ? (mm.)				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. DUE TO Acute urinary tract infection DUE TO Organ Undetermined.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1 June 1965 to 5 June 1965, that (I) (we) lost saw the deceased alive on 5 June 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE G. N. Riffle				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-5-65	
23C. PHYSICIAN'S NAME (Type) GEORGE N. RIFFLE JR.				23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JUNE 9 65		24C. NAME OF CEMETERY or CREMATORY ST PAUL'S CEMETERY		24D. LOCATION (City, town, or county) (State) BOSTON ST MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Riffle Bros 1800 E LOMBARD ST			

BIRTH NO.

65

6078

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65

6078

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES MILES KENLEY

2. DATE AND HOUR PRONOUNCED DEAD

June 9, 1965

2:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6103 Parkway Drive

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Mar. 18, 1901

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Seaboard Furnishing Co.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Joshua Kenley

14. MOTHER'S MAIDEN NAME

Millie Akers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Pauline Ayers Kenley, wife, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Exsanguination
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Carcinoma of Larynx.
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/9/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/12/65

23C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 10 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

3331 Brehms Lane

Mar. 10, 1901

Respectfully,
J. H. P.

John H. P.

Respectfully,
J. H. P.

Hartford, Ct.

Mar. 10, 1901

John H. P.

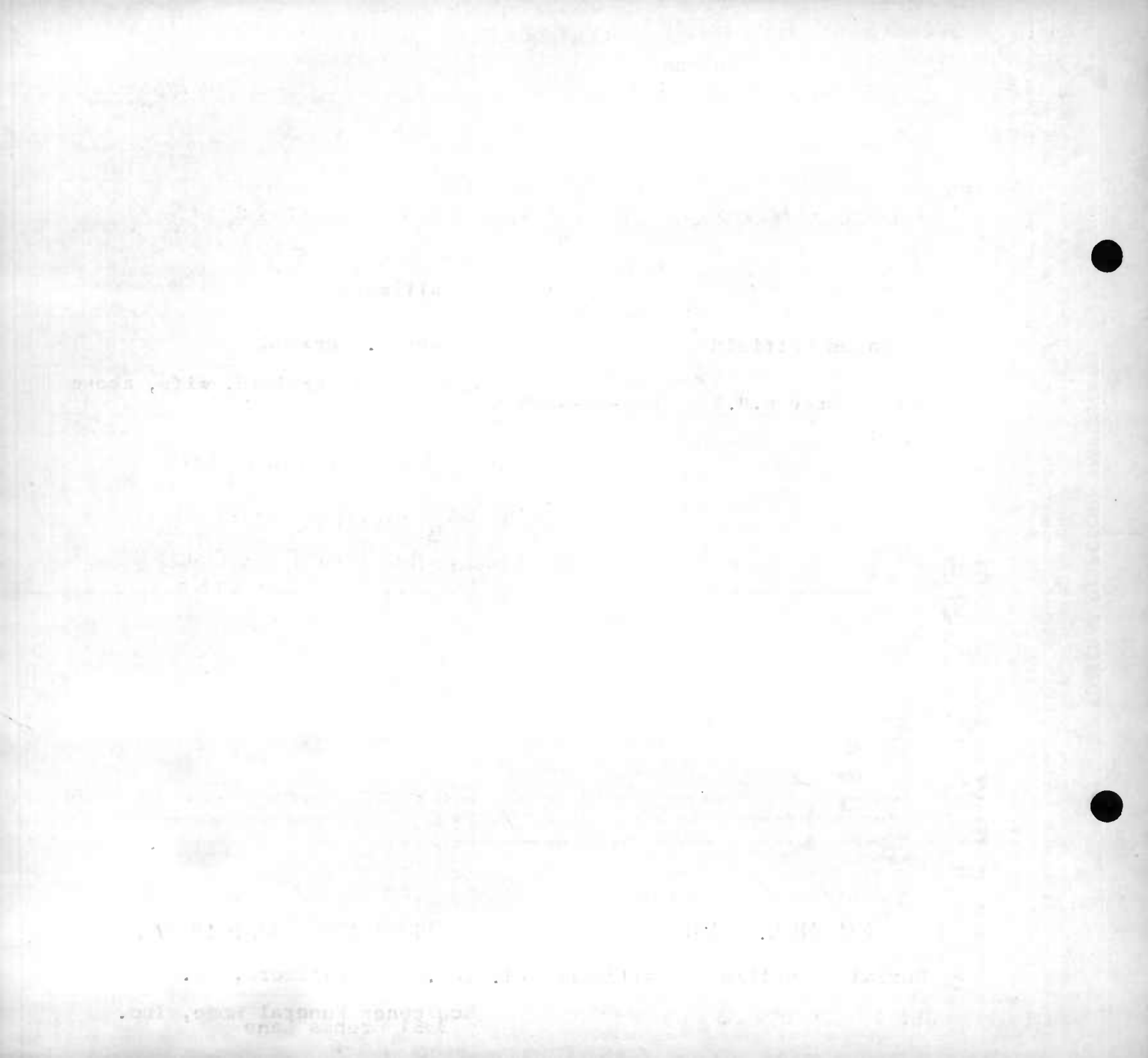
Respectfully,
J. H. P.

3531 Bridge Lane

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6079		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6079	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Eugene Francis E. Hatfield		2. DATE AND HOUR OF DEATH June 9, 1965 - 4:30 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 8-01			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3320 Cardenas Ave			
5. SEX m	6. RACE w	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) m	8. DATE OF BIRTH 11-28-07	9. AGE (In years last birthday) 57	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevedore
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Hatfield	
14. MOTHER'S MAIDEN NAME Mary M. Forwood		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes Army W.W.2		16. SOCIAL SECURITY NO. 214-03-4358	
17. INFORMANT Anna Albert Hatfield, wife, above		ADDRESS Wife - Anna - same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES		(A) DUE TO Bronchopneumonia, both lower lobes.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Coronary heart disease, severe			
		(C) Compensatory heart failure ARB			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-8-1965 to 6-9-1965, that (I) (we) last saw the deceased alive on 6-9-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Miriam L. Cohen		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-9-65	
23C. PHYSICIAN'S NAME (Type) MIRIAM L. COHEN		23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/11/65		24C. NAME OF CEMETERY or CREMATORY Baltimore Nat. Cem.	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. LOCATION (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1965 Robert E. Tarkenton		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										65 6080	
CERTIFICATE OF DEATH										Registered No.	
BIRTH NO.		65 6080									
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) Eugene ELLIS A SIMPSON				2. DATE AND HOUR OF DEATH 6. 7. 65.				8 35 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital. N. Broadway. Baltimore.				A. STATE MD. Baltimore				B. COUNTY Balt.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21222				53-00			
				D. STREET ADDRESS (If rural, give location) 41 Liberty Parkway.							
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married.		8. DATE OF BIRTH 7/14/01		9. AGE (In years last birthday) 63 yrs		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired steel worker.				10B. KIND OF BUSINESS OR INDUSTRY Steel worker.		11. BIRTHPLACE (State or foreign country) Virginia.		12. CITIZEN OF WHAT COUNTRY? U.S.R.			
13. FATHER'S NAME Richard Simpson				14. MOTHER'S MAIDEN NAME Lillian Campbell.							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 216-10-5160		17. INFORMANT Edith I. Simpson		ADDRESS same as #4			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Metastatic Ca. & acidosis. (B) DUE TO Ca. of lung (Post pneumonectomy) (C)				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) NO.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 4 th 1965 to June 7 th 1965, that (I) (we) last saw the deceased alive on 6. 7. 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Basu				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 6. 7. '65.			
23C. PHYSICIAN'S NAME (Type) Dr. N. BASU.				23D. ADDRESS Church Home & Hosp. Balt. U.S.A.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 6/11/65		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1965				25B. NAME OF REGISTRAR Robert E. Talbot				25C. FUNERAL DIRECTOR ADDRESS Walter Brooks Bradley, Inc., Dundalk 22			

1911/12

St. Albans
B. 1000

St. Albans
B. 1000

1911

1912

1913

1914

1915

St. Albans

St. Albans

St. Albans

St. Albans

St. Albans
B. 1000

NO

St. Albans
B. 1000

St. Albans
B. 1000

1
P-200

65 6081

BALTIMORE CITY HEALTH DEPARTMENT

65 6081

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JESSIE

DENITE

PHASEY

2. DATE AND HOUR PRONOUNCED DEAD

May 30, 1965

4:30 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

U.S. Public Health Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Towson

D. STREET ADDRESS (If rural, give location)

1 Centre Circle

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Aug 8 - 1901

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/30/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 10 1965

Robert E. Farley, M.D.

Earl B. Whelan Funeral Home

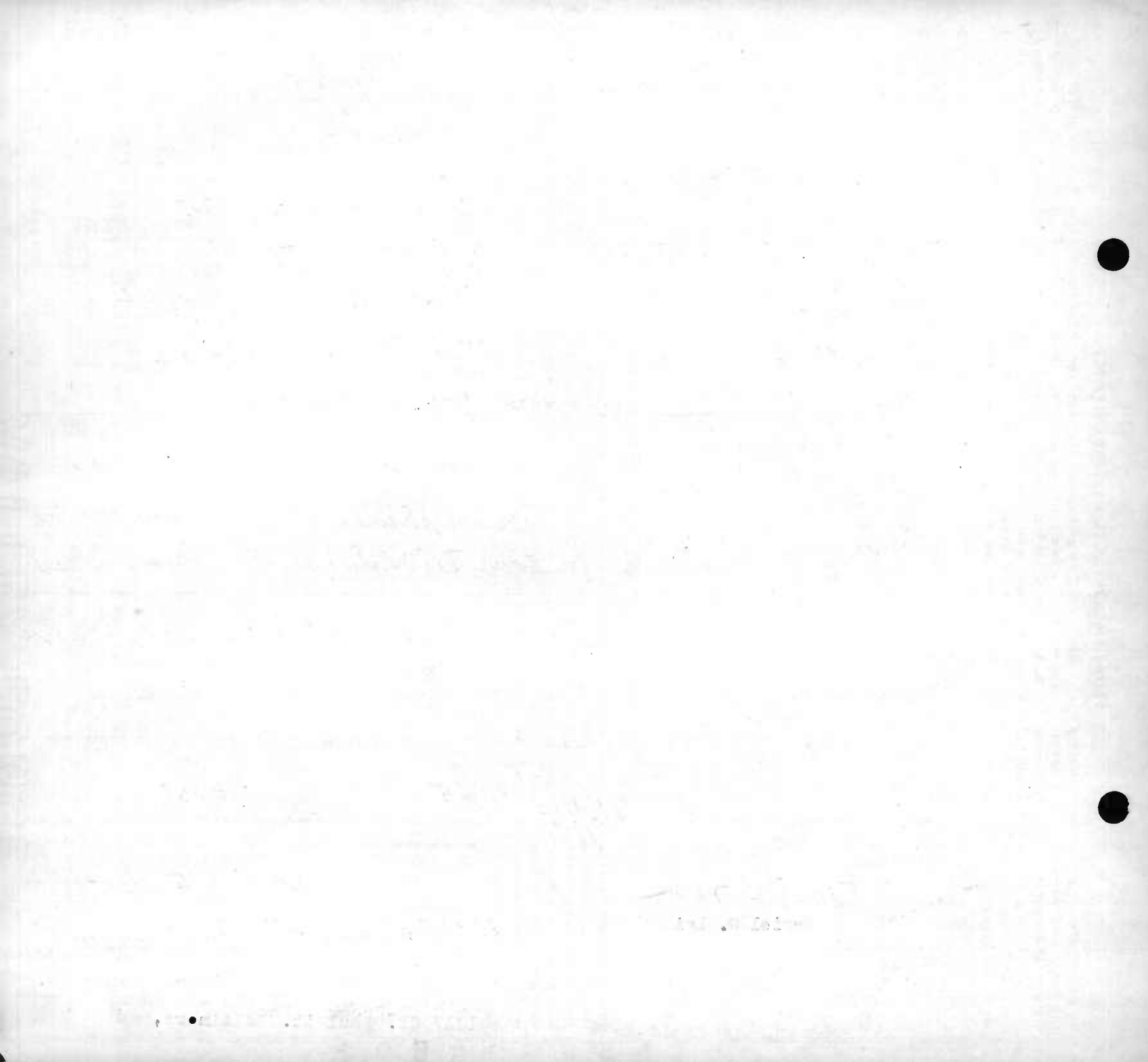
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
65 6082						65 6082	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
CARRIE ANDERSON				June 8, 1965 8:30 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
LUTHERAN HOSPITAL				Maryland Baltimore			
5. SEX				8. DATE OF BIRTH			
Female				4/5/99			
6. RACE				9. AGE (In years last birthday)			
Negro				66			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				10. KIND OF BUSINESS OR INDUSTRY			
Married				Private Families			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Pa.				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Ayers				Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				220 30 4143			
17. INFORMANT				ADDRESS			
Rufus Anderson				2434 Edmondson Ave.			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
Hypertensive and arteriosclerotic cardiovascular disease							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO			
				(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Diabetes mellitus			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
No							
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED			
(Month) (Day) (Year) (Hour)				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from:							
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
John E. Adams, M.D.				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)				23B. DATE			
Burial				6/II/65			
23C. NAME OF CEMETERY or CREMATORY				23D. LOCATION (City, town, or county) (State)			
Mt. Auburn				Balto. Md.			
24A. DATE REC'D BY HEALTH DEPT.				24B. NAME OF REGISTRAR			
JUN 10 1965				Robert E. Farley, M.D.			
24C. FUNERAL DIRECTOR				ADDRESS			
W.I. Chatman, Jr.				1701 McCulloh St.			

WALLEY FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 65 6083		CERTIFICATE OF DEATH	
M.E. CASE NO.		Registered No. 65 6083	
1. NAME OF DECEASED (Type or Print) <i>Vlachos, Florence</i>		2. DATE AND HOUR OF DEATH <i>6/8/65 1:00 P. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Montebello State Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1206</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>2624 St. Paul Street</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>11/26/1893</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>71</i>
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>John Hall</i>		14. MOTHER'S MAIDEN NAME <i>Marie Melanie Balplace</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>unknown</i>	17. INFORMANT ADDRESS <i>Hospital Records</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Uremia</i> DUE TO (B) <i>Pyelonephritis</i> DUE TO (C) <i>Diabetes Mellitus</i>	
INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>		<i>some months</i>	
<i>some years</i>		<i>some years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>arteriosclerotic heart disease</i>			
19A. DATE OF OPERATION <i>0</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <i>no</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/1/65</i> 19 to <i>6/8/65</i> 19, that (I) (we) lost saw the deceased alive on <i>6/8/65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Daniel G. Lai</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <i>5/8/65</i>
23C. PHYSICIAN'S NAME (Type) <i>Daniel G. Lai</i>		23D. ADDRESS M.D. <i>2201 Argonne Drive, Baltimore, Md</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>6/10/65</i>	24C. NAME of CEMETERY or CREMATORY <i>Greek Orthodox Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Woodlawn Baltimore County Md.</i>
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 10 1965</i>	25B. NAME OF REGISTRAR <i>Robert E. Farley</i>	25C. FUNERAL DIRECTOR <i>Wm Cook-Brooks, Inc</i> Address <i>1217 St. Paul St. Baltimore, Md</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6084	
BIRTH NO. 65 6084				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HAZEL K. WILLIAMS			2. DATE AND HOUR OF DEATH JUNE 8 - 1965 5:45 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY BALT.		
5. SEX F			6. RACE W		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED			8. DATE OF BIRTH 3-13-95		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			11. BIRTHPLACE (State or foreign country) W. VA.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 293-247636		
17. INFORMANT			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) HYPERNEPHROMA			INTERVAL BETWEEN ONSET AND DEATH 10 MOS.		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 3-22 19 65 to 6-8 19 65 , that (X) (we) last saw the deceased alive on 6-8 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Irving L. Cooperstein				23B. DATE SIGNED JUNE 8, 1965	
23C. PHYSICIAN'S NAME (Type) Irving L. Cooperstein				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/11/65		24C. NAME of CEMETERY or CREMATORY Beverly Hill Mem. Gardens	
24D. LOCATION (City, town, or county) (State) Morgantown, West Virginia		25A. DATE REC'D BY HEALTH DEPT. JUN 10 1965			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc., 1217 St. Paul Street			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 6085</u>	
BIRTH NO. <u>65 6085</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>GEORGE T. OLIVER</u>		2. DATE AND HOUR OF DEATH <u>6/8/65</u> <u>1 A.M.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore City</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>3205 Westerwald Ave, Zone 18</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>3205 Westerwald Ave</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED <u>Married</u> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>8/16/97</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Souse Chef</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>559-03-4702</u>		17. INFORMANT <u>Mrs Mary E. Oliver</u>	
				ADDRESS <u>Same as line 4</u>	
18. <u>181.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Squamous Carcinoma Bladder</u> (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>7 mo</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Metastatic Pyelonephritis</u> (B) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 Mo</u>			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> 19 <u>64</u> to <u>June 8</u> 19 <u>65</u> , that (I) (<u>X</u>) last saw the deceased alive on <u>June 8</u> 19 <u>65</u> and that in (my) (<u>X</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>W</u>) (did) (did <u>X</u> ot) view the body after death.					
23A. SIGNATURE <u>T.N. Wilson</u>		M.D. Attending <input checked="" type="checkbox"/> Phys. Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6/9/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>T.N. WILSON, M.D.</u>		23D. ADDRESS <u>617 W. 40th St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/11/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Oaklawn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, County, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 10 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Wm Cook-Brooks, Inc</u> <u>1217 St. Paul St. Baltimore, Md</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				65 6086		Registered No. 65 6086	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Edward Guyaux		6-8-65 1:35 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
Mercy				Maryland		27-07	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
M		W		W. Jones		5/10/1879	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Unknown				Belgium		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph Guyaux				Mary Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Unk				James A. Jobe		Turtle Creek, Pa.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Arteriosclerotic Cardiovascular Disease					
ANTECEDENT CAUSES		(B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO					
II		Sigmoid Volvulus					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
16-4-65		Sigmoid Volvulus		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 6-3-65 to 6-8-65, that (I) (we) last saw the deceased alive on 6-8-65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Perry S. Shelton						6-8-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Perry S. Shelton				Mercy Hospital, Baltimore, Md.			
24A. BURIAL CREMATION/REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/11/65		Church Hill Cemetery		Wikens township, Alagheny, Pa	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JUN 10 1965		Robert S. Johnson		Wm. Cook-Brooks, Inc., 1217 St. Paul Street			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

65 6087

CERTIFICATE OF DEATH

Registered No.

65 6087

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Norma Sykes

2. DATE AND HOUR OF DEATH

6-9-65

3:00 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1007 Mc Aleer Court

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

7-7-92

9. AGE (In years
last birthday)

72

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Thomas Brooks

14. MOTHER'S MAIDEN NAME

Mary E. Demines

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-12-4251

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18. 170 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of Breast with Metastasis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐
WorkNot While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-4-1965 to 6-9-1965,
that (I) (we) lost saw the deceased alive on 6-9-1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

H. Rathbun

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6-9-65

23C. PHYSICIAN'S
NAME (Type)

Dr. Howard Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6-12-65

24C. NAME OF CEMETERY or CREMATORY

MT. CALVARY

24D. LOCATION

A. A. Co.

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 10 1965

25B. NAME OF REGISTRAR

Robert E. Faldut

25C. FUNERAL DIRECTOR

Morton + Dye II

ADDRESS

1701 Laurens St.

100

1901 Census

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 6088		CERTIFICATE OF DEATH		65 6088	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		Vukcevic, Jennie		6-9-65 6:15 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY		Md. 19-83	
34 Bon Secours Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		1300 Mc Henry St.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
F	W	MARRIED	3-16-99	66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
	Housewife	Yugoslavia	U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		ADDRESS	
Javanovich, John		Minnie Zirkovich			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		
No			Front Sheet.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ACUTE ANTERIOR LOTUS MYOCARDIAL INFARCT.		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Common heart diseases			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-28 1965 to 6-9 1965, that (I) (we) last saw the deceased alive on 6-9-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Jaimie Perera				6-9-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Jaimie Perera		Bon Secours Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	6/14/65	Fredrick Park Cemetery	Baltimore, Maryland		
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 10 1965		E. J. J. J.		Walter Funeral Home, 1111 N. E. St.	

CERTIFICATE OF DEATH

Registered No. 65 6089

BIRTH NO. 65-11471 65 6089

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)Baby Girl ~~Ingram Dorothea~~ Ingram

2. DATE AND HOUR OF DEATH

5-19-1965

2:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1208 Waldo Court

21202

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married

8. DATE OF BIRTH

5-16-1965

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

3

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Dorothea Ingram

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue

21224

18. 754.51

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Cardiac Failure
DUE TO

10 hours ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) Congenital Heart Disease
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (nately medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At
Work ☐Not While
At Work ☐22. I certify that (I) (this hospital) attended the deceased from 5-16-1965 to 5-19-1965,
that (I) (we) last saw the deceased alive on 5-19-1965 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

S. Wayne Klein

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

5-19-1965

23C. PHYSICIAN'S
NAME (Type)

Dr. S. Wayne Klein

23D. ADDRESS

M.D.

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

24B. DATE

5-20-65

24C. NAME of CEMETERY or CREMATORY

Baltimore City Hospitals

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUN 10 1965

25B. NAME OF REGISTRAR

Robert E. Taylor

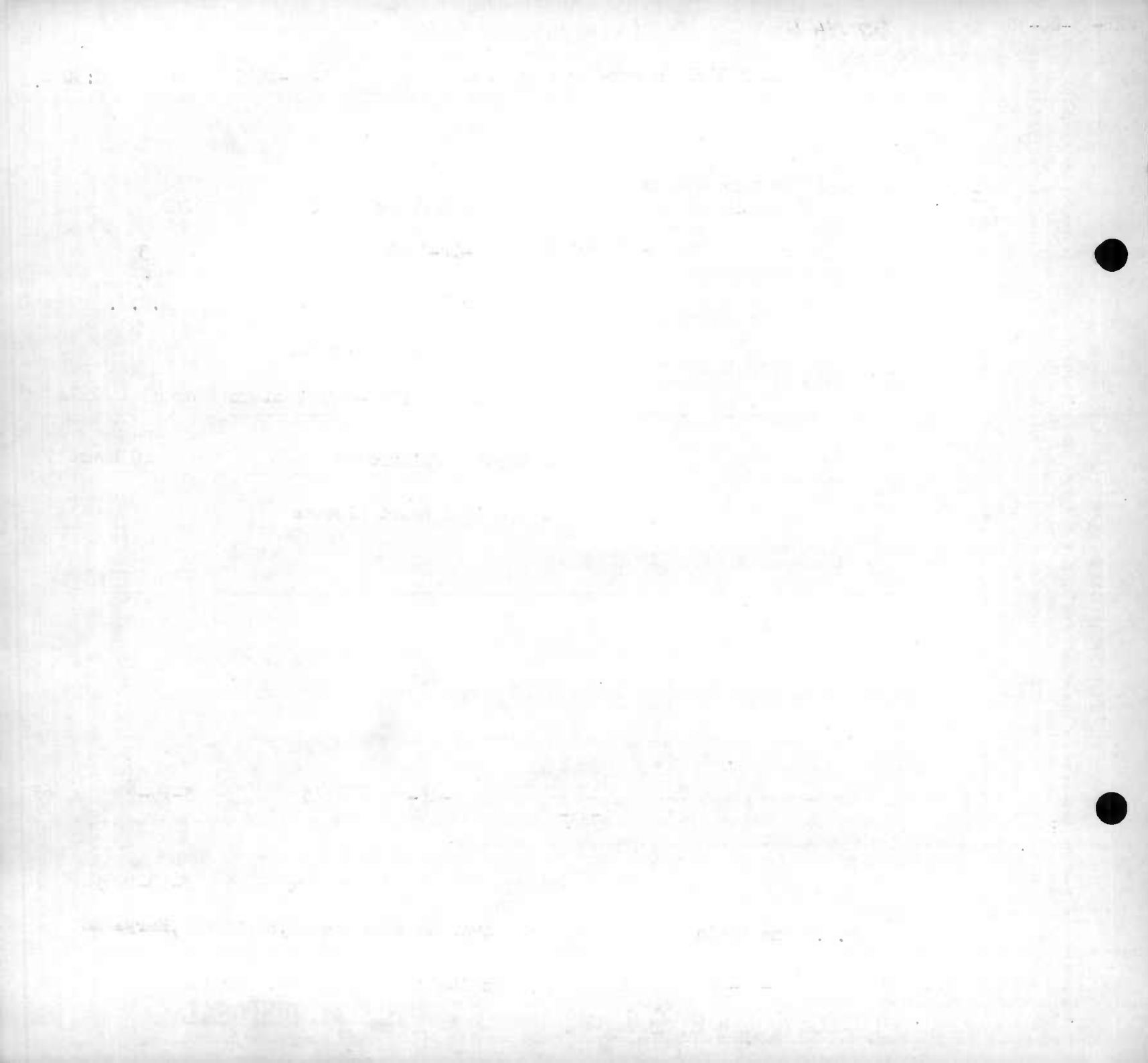
25C. FUNERAL HOME

HOSPITAL DISPOSAL

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

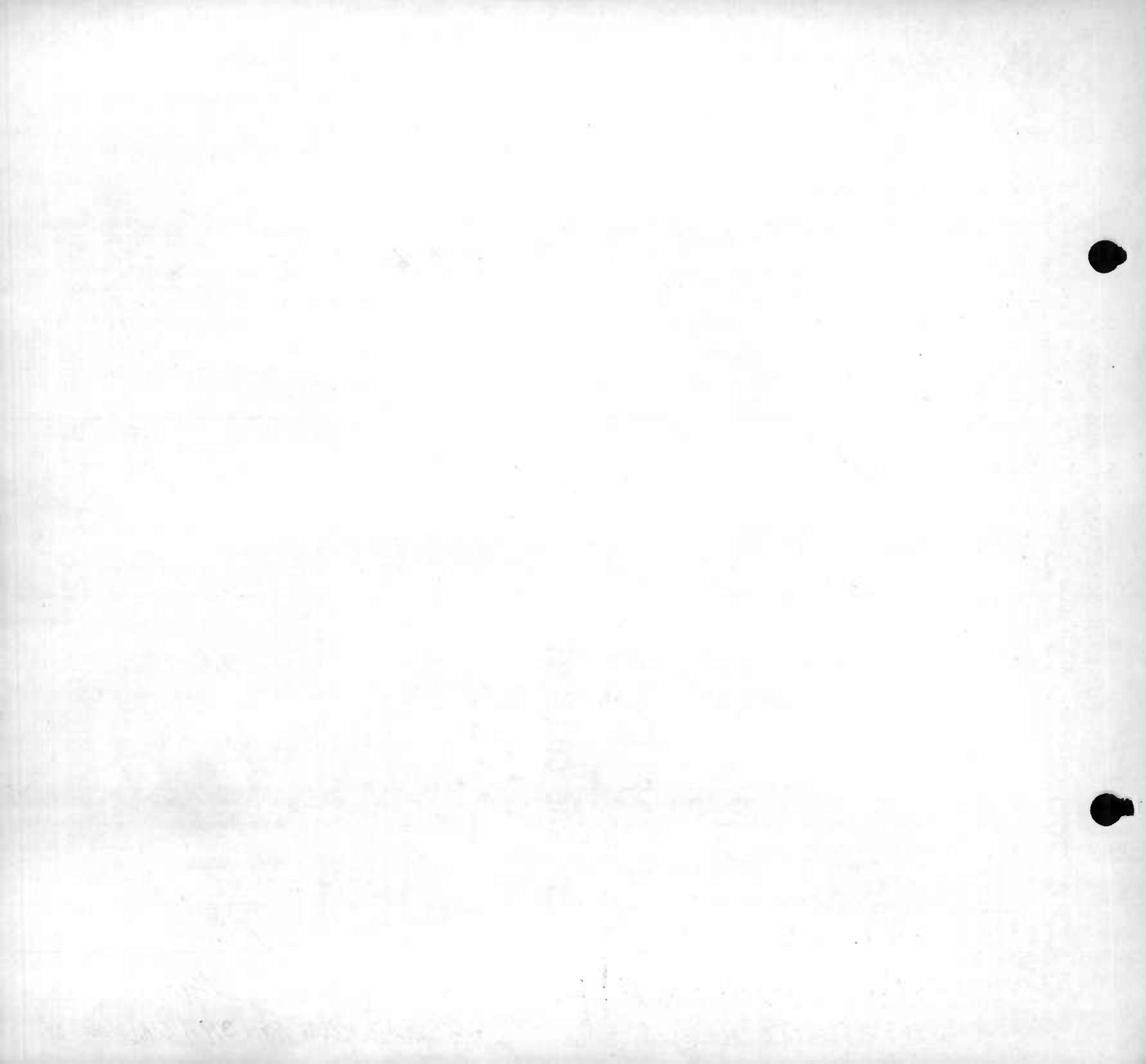
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6090	
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <i>MARY GRACE SMITH</i>		2. DATE AND HOUR OF DEATH <i>6-8-65 3:15 PM</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		A. STATE <i>B. Maryland</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>2534 W. Baltimore Street</i>			
5. SEX <i>Female</i>	6. RACE <i> negro</i>	7. MARRIED, NEVER MARRIED WIDOWED <i>Widowed</i>	8. DATE OF BIRTH <i>8/30/91</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Charles C. Smith</i>		14. MOTHER'S MAIDEN NAME <i>Mary Virginia Greenfield</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>Chert</i>	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <i>Pericardial Cardiac Disease</i> DUE TO <i>Disease</i>		<i>10 yrs.</i>	
		(B) <i>Atrial Fibrillation</i> DUE TO		<i>7 1/2 yrs.</i>	
		(C) <i>R/O Pulmonary Embolism</i> <i>R/O Acute Myocardial Infarction</i>		<i>5 minutes</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <i>6-7-65</i> 19 to <i>6-8-65</i> 19, that (I) <u>(we)</u> last saw the deceased alive on <i>6-8-65</i> 19, and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <i>John J. Messina MD</i>				23B. DATE SIGNED <i>6-8-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>John J. Messina</i>				23D. ADDRESS <i>University Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/2/1965</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn Cem. Balt. Md.</i>	
24D. LOCATION (City, town, or county) (State) <i>Balt. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 10 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Feltman</i>	
25C. FUNERAL DIRECTOR <i>Williams Funeral Home</i>		25D. ADDRESS <i>3928 Schroeder St.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

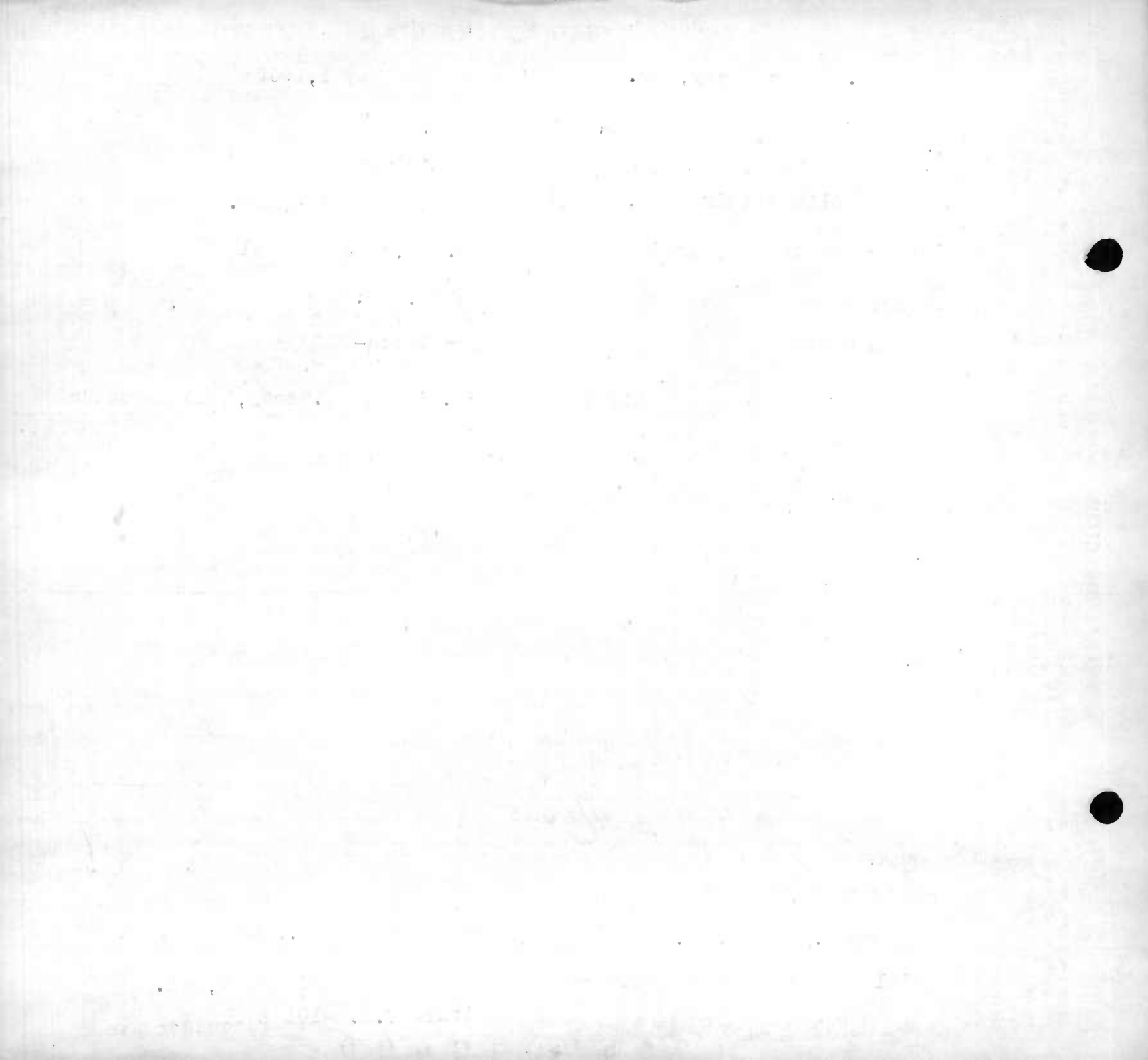
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6091	
BIRTH NO. 65 6091		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN A. BRENNER	
2. DATE AND HOUR OF DEATH JUNE 8, 1965 11:50 PM EDT M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-48	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL BALTIMORE 1, MD.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
		D. STREET ADDRESS (If rural, give location) 5830 NORTHWOOD DRIVE	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3/25/09
9. AGE (In years lost birthday) 56		10. CITIZEN OF WHAT COUNTRY? USA	11. BIRTHPLACE (State or foreign country) FLORIDA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY		10B. KIND OF BUSINESS OR INDUSTRY SOC. SEC. ADM.	
13. FATHER'S NAME WILLIAM L. BRENNER		14. MOTHER'S MAIDEN NAME MARY FRANCIS THOMAS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT RUTH P. BRENNER		ADDRESS SAME	
18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) UREMIA		INTERVAL BETWEEN ONSET AND DEATH 1 MO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION last. ARTERIOLOPHROSCLEROSIS 7.6 MO.		(B) DUE TO —	
(C) DUE TO —			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HYPERTENSIVE CARDIOVASCULAR DISEASE, RIGHT RENAL ARTERY STENOSIS			
19A. DATE OF OPERATION —	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 18 19 65 to JUNE 8 19 65 , that (I) (we) last saw the deceased alive on JUNE 8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE David M. Shearer, M.D. M.D.		23B. DATE SIGNED 6/8/65	
23C. PHYSICIAN'S NAME (Type) David M. Shearer M.D. M.D.		23D. ADDRESS UNIV. HOSPITAL, BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/11/1965	24C. NAME OF CEMETERY or CREMATORY St. Mary's	24D. LOCATION (City, town, or county) (State) Jacksonville, Fla.
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1965	25B. NAME OF REGISTRAR Robert E. Hall	25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	

OFFICE
OF THE
SHERIFF
COUNTY OF
SANTA BARBARA
CALIFORNIA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6092		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6092	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) J. Marion Seney, Sr.			May 1, 1965 9:50 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould Nursing Home 6116 Belair Road, zone 6			A. STATE Md. B. COUNTY 9-02		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 1716 Lakeside Ave.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED Married	8. DATE OF BIRTH Dec. 26, 1883	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME Joshua Seney		12. CITIZEN OF WHAT COUNTRY? USA			
14. MOTHER'S MAIDEN NAME Henrietta-					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217 18 9595		17. INFORMANT ADDRESS Mrs. Mildred V. Seney, 1716 Lakeside A	
18. 4-22-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19-53 to 5/1/65 19 53 that (I) (we) last saw the deceased alive on 4/28/65 19 53 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas L. Worsley, Jr.				23B. DATE SIGNED 5/3/65	
23C. PHYSICIAN'S NAME (Type) Thomas L. Worsley, Jr.				23D. ADDRESS 2900 Alameda Blvd., Baltimore, Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 3/65		24C. NAME OF CEMETERY or CREMATORY Lorraine Park	
24D. LOCATION Baltimore 7, Md.		25C. FUNERAL DIRECTOR ADDRESS Witzke F.D. 4101 Edmondson Ave			
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1965		25B. NAME OF REGISTRAR Robert E. Falek		25D. ADDRESS Edmondson Ave	



1
B260

BALTIMORE CITY HEALTH DEPARTMENT				65 6093	
BIRTH NO.				MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		JOHN BOWSER, Jr.		2. DATE AND HOUR PRONOUNCED DEAD June 9, 1965 2:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		B. COUNTY Baltimore 14-02	
D. STREET ADDRESS (If rural, give location)		1409 McCulloh Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 530, 36	9. AGE (In years last birthday) 29	If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Weldon, N.C.	
13. FATHER'S NAME John Bowser		14. MOTHER'S MAIDEN NAME Mary Hopkins		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 243-50-3149		17. INFORMANT Merry Martiney 910 Baltimore Street Apt 25	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty Liver. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/9/65	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE 6/13/65		23C. NAME OF CEMETERY or CREMATORY Chick Cemetery	
23D. LOCATION (City, town, or county) (State)		Weldon, N.C.			
24A. DATE REC'D BY HEALTH DEPT. JUN 10 1965		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR Walter L. M. Higgins 2302 W. North Ave	

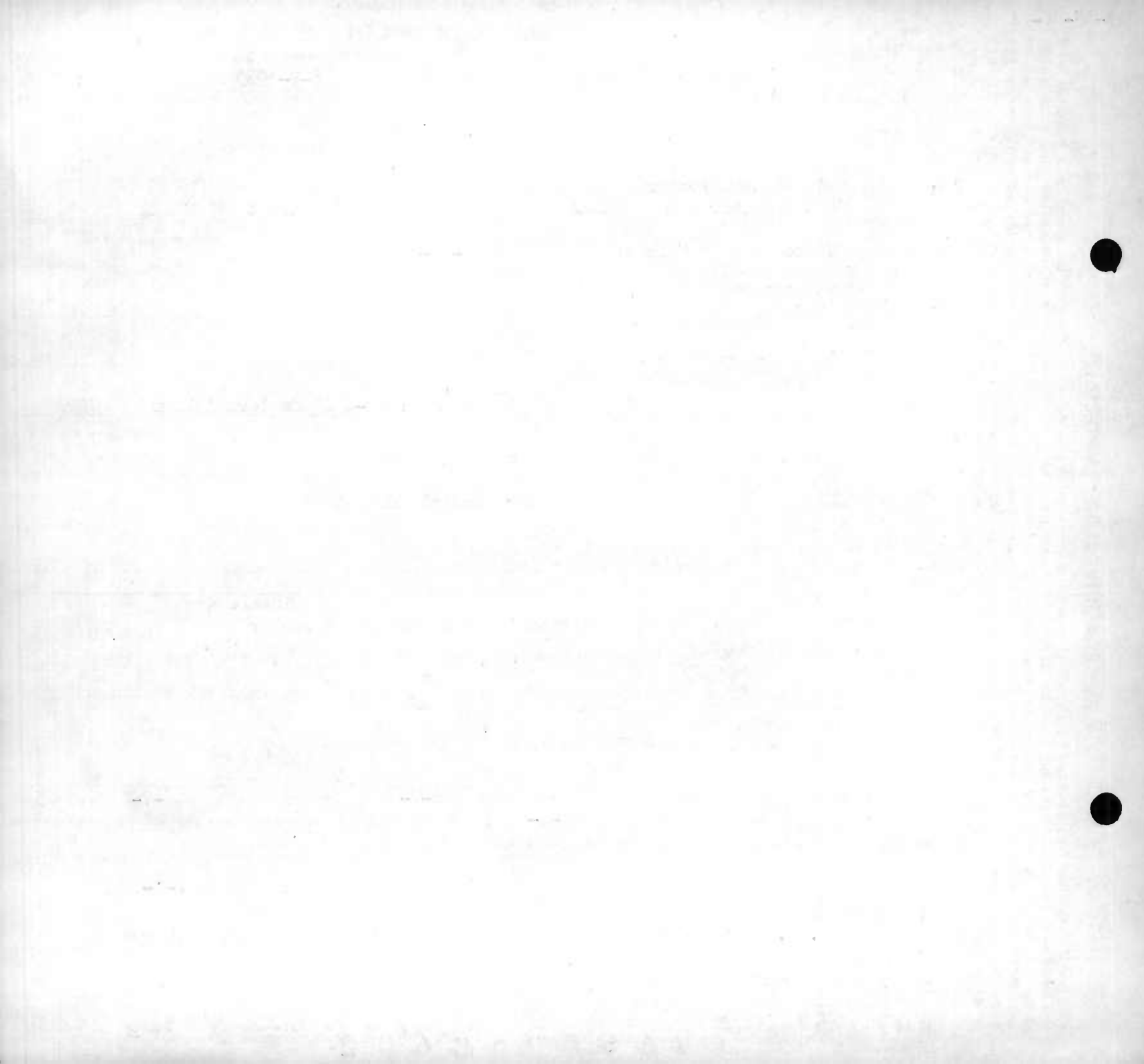
VALLEY FORGE

MEMORANDUM

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		M.E. CASE NO.		Baltimore City Health Department		Registered No.	
E-413		65 6094		CERTIFICATE OF DEATH		65 6094	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
John Eleftheriou				6-7-1965 12:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				Maryland Baltimore			
5. SEX				6. RACE			
Male				White			
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH			
Married				3-13-1892			
9. AGE (In years lost birthday)				10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
73				Grocery St.			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Greece							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Dimitrios Eleftheriou				unk.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No.				236-03-4865			
17. INFORMANT				ADDRESS			
Records: BCH-4940 Eastern Avenue				21224			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Cardiac Arrest			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				Myocardial Infarction			
ANTECEDENT CAUSES				2 Hours			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II				Disease			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Arteriosclerotic Cerebral Vascular			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
				No			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
No							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 6-7-19 65 to 6-7-19 65, that (I) (we) last saw the deceased alive on 6-7-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
H. Rathbun				6-7-1965			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. H. Rathbun				4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				6/9/65			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Gr. Ormadox Cem.				Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
JUN 10 1965				Robert E. Starkey			
25C. FUNERAL DIRECTOR				ADDRESS			
Joseph N. Zennaro Jr.				263 S. Condit St.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

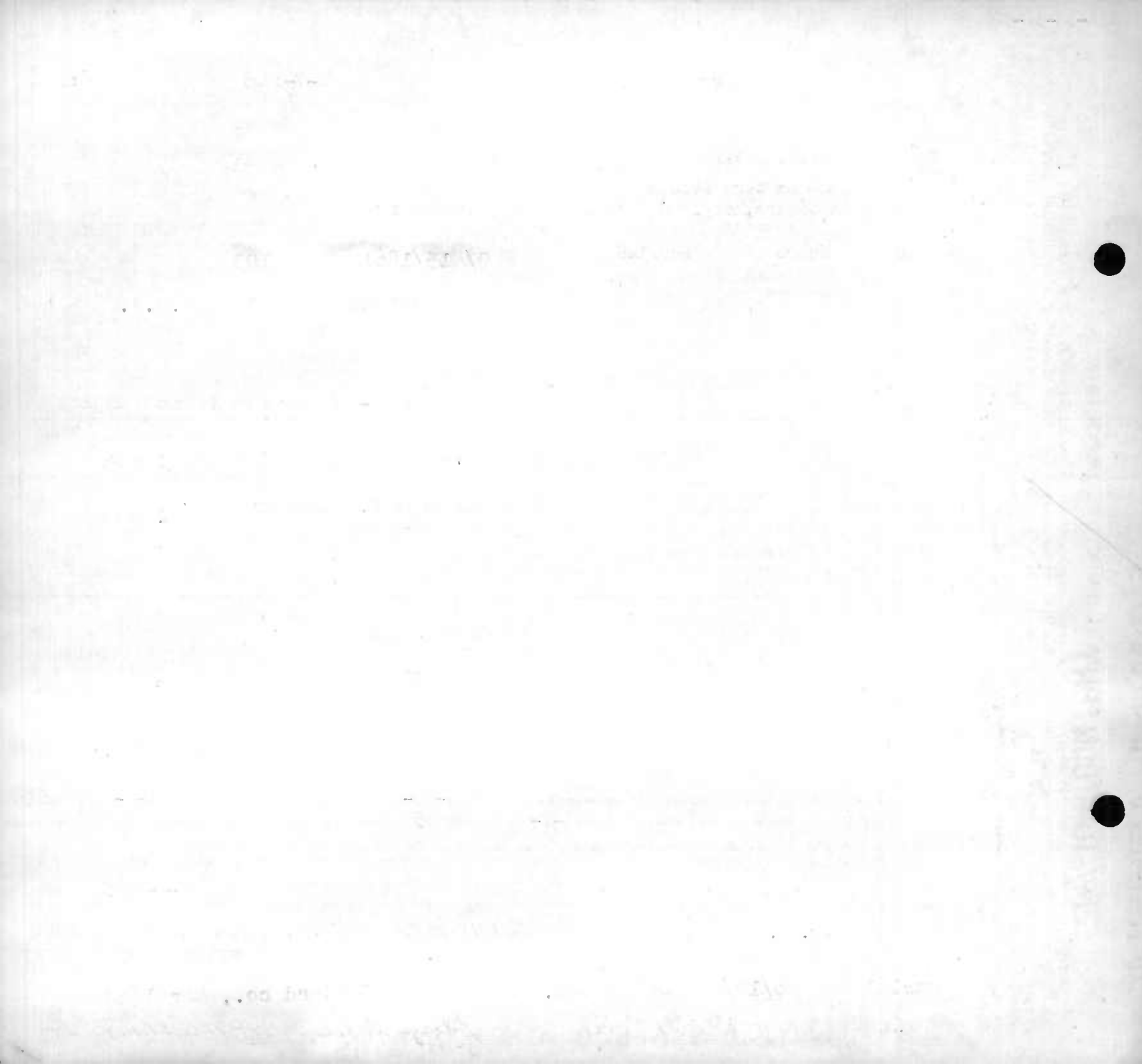
VS 150-REV. 1/1/65

for J. C. C. C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

SAB-38-30-52		65 6096		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6096	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Harry Dorsey				6-7-1965		6:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				Maryland		Howard	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Rural			
				D. STREET ADDRESS (If rural, give location)			
				Woodbine			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
Male	Negro	Married	9/ 15/1861	103			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				Records: BCH-4940 Eastern Avenue 21224			
18. 334X I CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) Aspiration Pneumonia			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				DUE TO			
ANTECEDENT CAUSES				Cerebral Occlusive Vascular Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Possible Sepsis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-19-19 65 to 6-7-19 65, that (I) (we) last saw the deceased alive on 6-7-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. H. Rathbun				M.D. 4940 Eastern Avenue, Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/12/65		Daisy Cem.		Howard co., Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JUN 10 1965		Robert E. Fink		George S. Fink 1348 N. Calhoun St.			



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

2. DATE AND HOUR PRONOUNCED DEAD

June 10, 1965 2:59 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2928 Presstman St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

1-2-94

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William Bumbray

14. MOTHER'S MAIDEN NAME

Roberta Wanser

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWI

16. SOCIAL
SECURITY NO.

218-03-1306

17. INFORMANT

ADDRESS

Rebecca Bumbray 2928 Presstman St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of the stomach with
DUE TO metastases

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-10-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-14-65

23C. NAME of CEMETERY or CREMATORY

Baltimore Natl. Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 10 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

George A. Kilar 1548 N. Calhoun St.

FUNERAL DIRECTOR: IMPORTANT

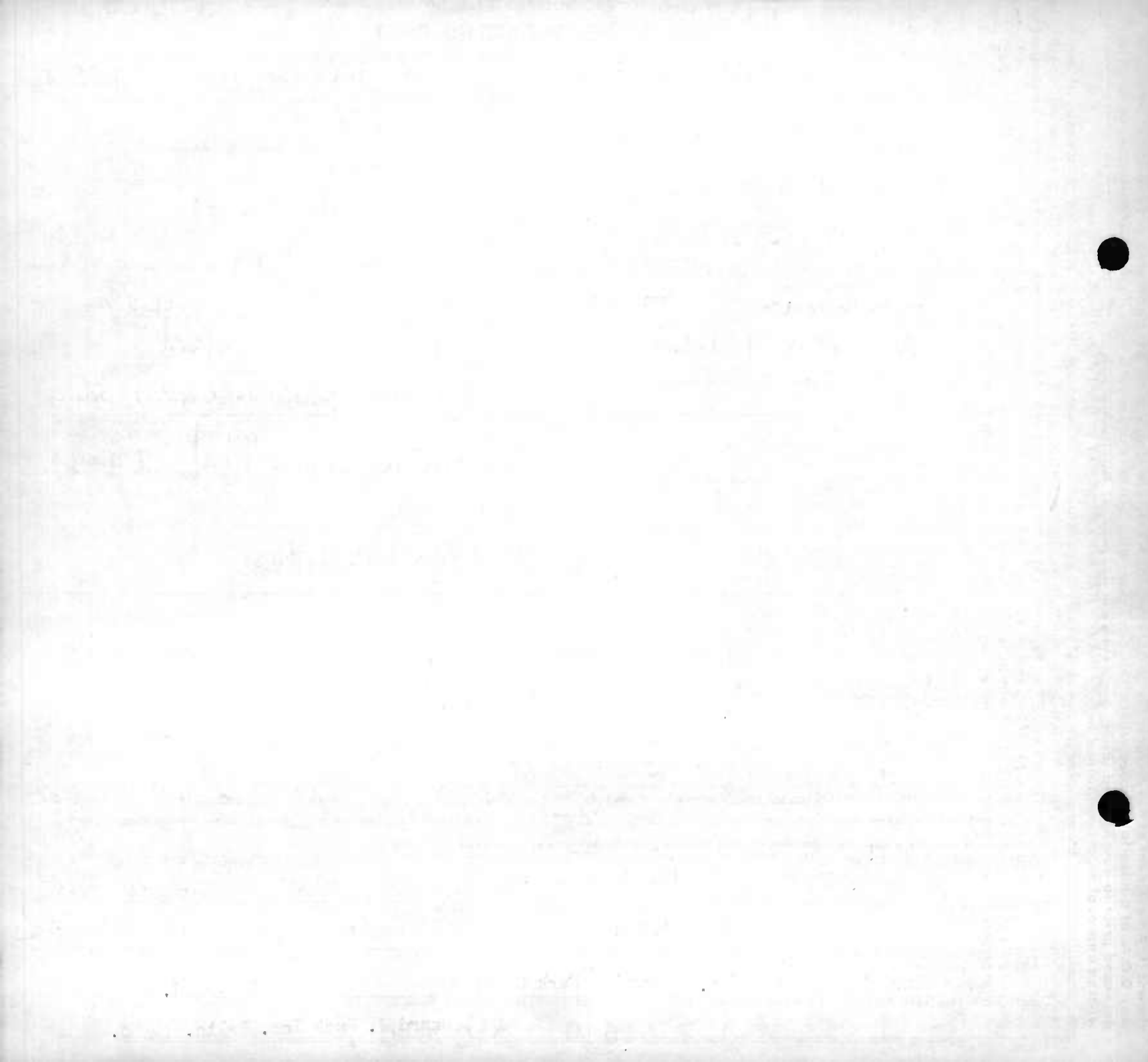
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6098	
BIRTH NO. 65 6098				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) LULA LORD			2. DATE AND HOUR OF DEATH June 17, 1965 5:15 p. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 502 Sanford Place			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 502 Sanford Place		
5. SEX female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 12/28/1864	9. AGE (In years last birthday) 100	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Myrtle Wilson		
ADDRESS 502 Sanford Place			18. CAUSE OF DEATH		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) CARDIO VASCULAR DISEASE (B) _____ (C) _____		
INTERVAL BETWEEN ONSET AND DEATH 2 YRS			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 27 1965 to JUNE 7 1965 , that (I) (we) lost saw the deceased alive on JUNE 5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William Frey			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/10/65
23C. PHYSICIAN'S NAME (Type) EWILLIAM FREY			23D. ADDRESS 1928 PENNA. AVE BALTO MD		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/10/65		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 10 1965			
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR George A. Filer			
ADDRESS 1348 N. Calhoun St					

FUNERAL DIRECTOR: IMPORTANT


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

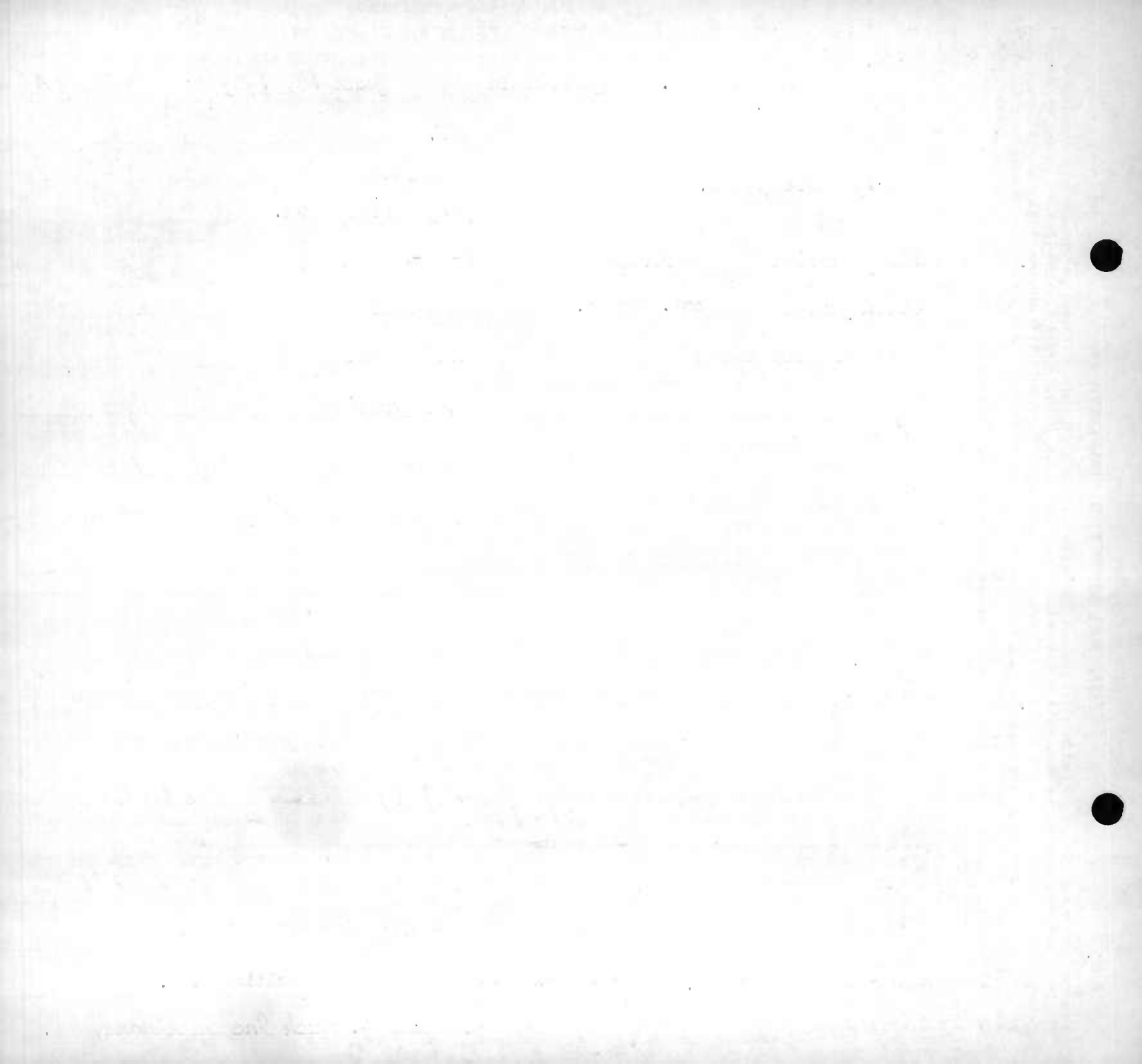
BIRTH NO. 65 6099		BALTIMORE CITY HEALTH DEPARTMENT		65 6099	
CERTIFICATE OF DEATH				Registered No. _____	
1. NAME OF DECEASED (Type or Print)		Mrs. Pastorius, Eva. F.		2. DATE AND HOUR OF DEATH June 10, 1965 1:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland			
Baltimore General Hospital		B. COUNTY 26-01			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 5903 Grace Ave. #6			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 6-25-1909	9. AGE (In years last birthday) 55 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Nicholas Buchani		14. MOTHER'S MAIDEN NAME Marian Sparacina	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Marianne Pastorius (daughter) Same.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) 260X I		CAUSE OF DEATH (A) DUE TO Diabetic Coma and Uremia.		INTERVAL BETWEEN ONSET AND DEATH 2 days.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Diabetes Mellitus			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-8 1965 to 6-10 1965, that (I) (we) last saw the deceased alive on 6-10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ey Kol Koh		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-10-65	
23C. PHYSICIAN'S NAME (Type) Ey Kol Koh		23D. ADDRESS Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/14/65		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1965		25B. NAME OF REGISTRAR Robert E. Fagley		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. 14 Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

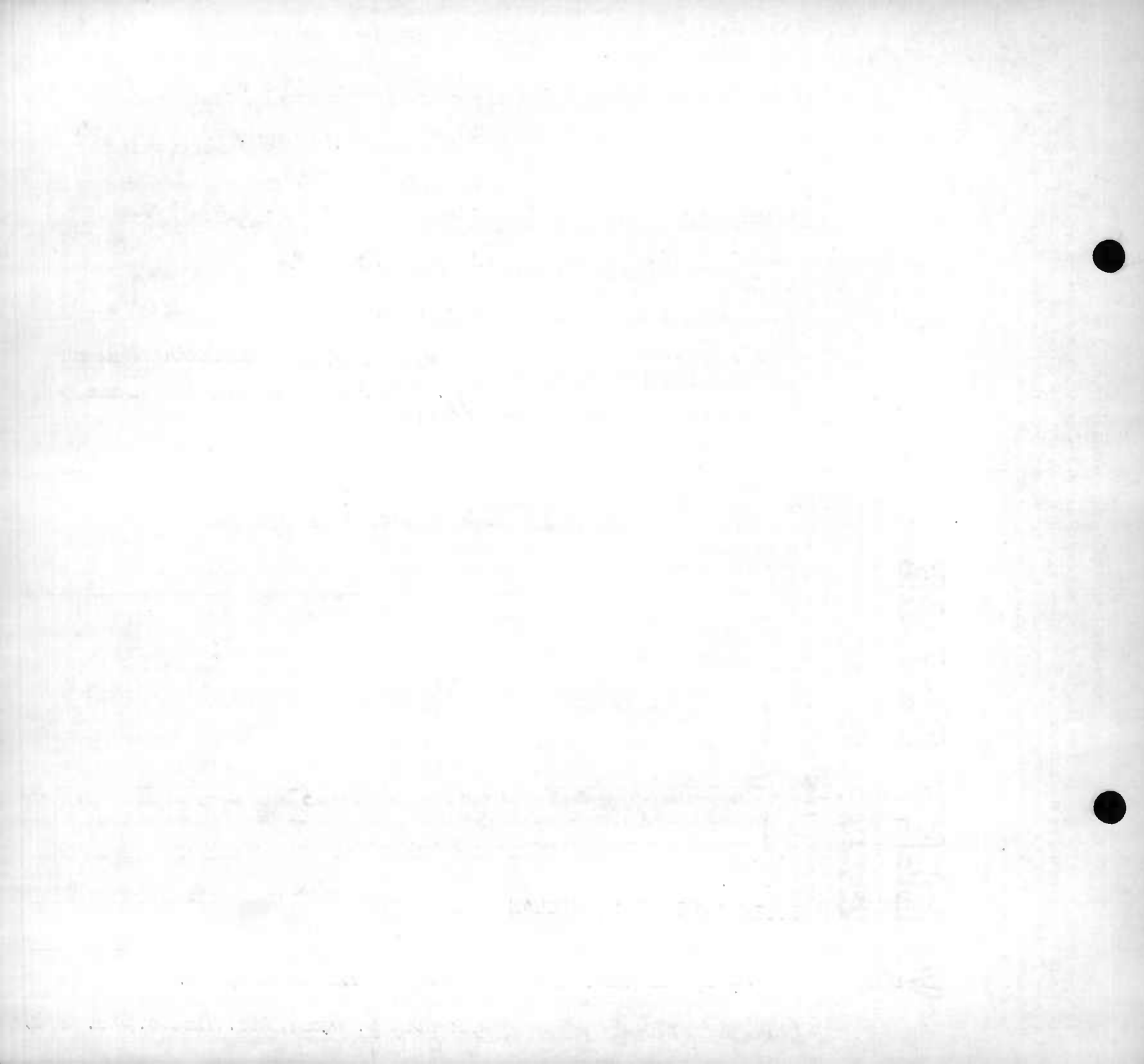
BIRTH NO. 65 6100				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 65 6100	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Thomas W. Cunningham				2. DATE AND HOUR OF DEATH June 10, 1965 3:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4613 Schley Ave.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #6 D. STREET ADDRESS (If rural, give location) 4613 Schley Ave.			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 11-22-1890		9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Guard		10B. KIND OF BUSINESS OR INDUSTRY Cont. Can Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Cunningham				14. MOTHER'S MAIDEN NAME Annie Rooney			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Annie Cunningham		ADDRESS same	
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinomatosis, generalized ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. carcinoma of lung				(A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 month 4 mo.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/3/1952 to 6/9/65 19____, that (I) (we) last saw the deceased alive on 6/4/65 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (do not) view the body after death.							
23A. SIGNATURE  MARION FRIEDMAN M.D.				23B. DATE SIGNED 6/9/65		23C. PHYSICIAN'S NAME (Type) MARION FRIEDMAN	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/65		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc		ADDRESS Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6101	
65 6101				BIRTH NO.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Sophia L. Coulson			2. DATE AND HOUR OF DEATH June 10 - 65 9:05 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1356 Pentridge R.D.		
5. SEX Female	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 12-18-1911	9. AGE (In years last birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME EINOLF, Conrad			14. MOTHER'S MAIDEN NAME Katherine Neuman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Mr. William Coulson, Chelt		ADDRESS Same
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) Arteriosclerotic Cardiovascular Disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Immediate
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 5-29-1965 to 6-10-1965 , that (H) (we) last saw the deceased alive on 6-10-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ellen Anne Dagan Millan M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED June 10, 1965	
23C. PHYSICIAN'S NAME (Type) DR ELLEN ANNE DAGAN MILLAN				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/14/65	24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 10 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md. ADDRESS 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 6102		65 6102			
<div> <div>M.E. CASE NO.</div> <div>1. NAME OF DECEASED (Type or Print)</div> <div>2. DATE AND HOUR OF DEATH</div> </div>					
Kennedy, John F.		6-7-65 12:55 AM			
<div> <div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</div> </div>					
<div> <div>FULL NAME OF HOSPITAL OR INSTITUTION</div> <div>(If not in hospital or institution, give street address or location)</div> </div>		<div> <div>A. STATE</div> <div>B. COUNTY</div> </div>			
Maryland General Hospital Linden + Madison Sts.		Maryland (Name) 9-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3627 Yolando Rd.			
5. SEX Male		6. RACE Caucasian		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	
10A. USUAL OCCUPATION (Give kind of work done during normal working life, even if retired) Owner		10B. KIND OF BUSINESS OR INDUSTRY INVESTMENTS		8. DATE OF BIRTH 5-2-94	
13. FATHER'S NAME Michael J. Kennedy		14. MOTHER'S MAIDEN NAME Ella R. Burke		9. AGE (in years last birthday) 71	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-12-464		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 260 X 14381.1		17. INFORMANT J. F. Kennedy Jr. 4235 Hickford Rd.		12. CITIZEN OF WHAT COUNTRY? USA	
19. DATE OF OPERATION 0		20. AUTOPSY? (Yes or No) No		19. AGE (in years last birthday) 71	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? None	
22. I certify that (I) (this hospital) attended the deceased from 6-6-65 to 6-7-65, that (I) (we) last saw the deceased alive on 6-7-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE L. Kemper Owens		23B. DATE SIGNED 6-7-65	
23C. PHYSICIAN'S NAME (Type) L. KEMPER OWENS		23D. ADDRESS MARYLAND GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/10/65		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR H. W. MEARS & SON 805 N. CALVERT	
25D. LOCATION (City, town, or county) (State) BALTIMORE, MD.		25E. ADDRESS 805 N. CALVERT			

TO THE HONORABLE SECRETARY OF THE INTERIOR

DEAR SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the application of the late John A. Smith for a patent for an improvement in the method of manufacturing paper. The same has been referred to the proper authorities for their consideration.

I am, Sir, very respectfully,
Your obedient servant,
J. M. Smith

Very truly,
J. M. Smith
J. M. Smith & Co.,
Manufacturers of Paper,
New York City.

BIRTH NO. **65 6108** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **65 6103**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

William H. Kammer, Sr.

2. DATE AND HOUR PRONOUNCED DEAD

June 6, 1965

12:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

701 E. Preston Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

Oct. 5, 1887

9. AGE (In years
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

PHARMACIST

10B. KIND OF BUSINESS OR INDUSTRY

OWN BUSINESS

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

DANIEL KAMMER

14. MOTHER'S MAIDEN NAME

ANNA LIST

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

DR. W. H. KAMMER, JR 612 W. 40TH ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 6, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

6/9/65

23C. NAME of CEMETERY or CREMATORY

LODGE PARK

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MD.

24A. DATE REC'D BY HEALTH DEPT.

JUN 11 1965

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

H. W. MEARS & SON 805 N. CALVERT ST.

ADDRESS

100

OCT. 10, 1927

BALTIMORE, MD.

ST. BERNARD

CHANNACOT

ANNAL BOOK

UNITED STATES

W. W. F. FARRER, JR. 619 W. 10TH ST.

BALTIMORE, MD.

ST. BERNARD

CHANNACOT

W. W. F. FARRER, JR. 619 W. 10TH ST.

65 6104

BALTIMORE CITY HEALTH DEPARTMENT

65 6104

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANITA

HAWKINS

2. DATE AND HOUR PRONOUNCED DEAD

June 8, 1965

19:17 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION

University Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

342 Bloom Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorce

8. DATE OF BIRTH

Feb. 7, 1914

9. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Seamstress

10B. KIND OF BUSINESS OR INDUSTRY

Hutzler

11. BIRTHPLACE (State or foreign country)

Baltimore Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Herbert Tankard

14. MOTHER'S MAIDEN NAME

Susie Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). If yes, give war or dates of service

No

16. SOCIAL
SECURITY NO.

218-03-9430

17. INFORMANT

ADDRESS

Dazee Rowlings, 2602 Chelsea Terrace

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic and Hypertensive
~~PHOTO~~ Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? If in Baltimore City, give exact location21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/9/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

June 12, 65

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

Baltimore

Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 11 1965

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

Charles R. Law 802 Madison Ave.

ADDRESS

WILLIAM

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 6105					65 6105				
BIRTH NO.					Registered No.				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
LOTTERER, LEO J					6-5-65 6:40 PM.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
ST. AGNES HOSPITAL BALTIMORE, MARYLAND 21229					MARYLAND				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					BALTIMORE				
					D. STREET ADDRESS (If rural, give location)				
					1801 ARBUTUS AVENUE				
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MALE		WHITE		MARRIED		3-12-91		74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY				
Capt. Fire Dept					RETIRED				
11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
MARYLAND					U.S.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
HERMANN LOTTERER (DEC'D)					MARIA (DEC'D)				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
UNKNOWN					21632-330				
17. INFORMANT					ADDRESS				
					ST. AGNES HOSPITAL RECORDS BALTO. 29, MD				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					Chronic bronchitis & emphysema				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>							
22. I certify that (H) (this hospital) attended the deceased from 5-16-1965 to 6-5-1965, that (X) (we) last saw the deceased alive on 6-5-1965 and that in (XXX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE								23B. DATE SIGNED	
William A. Dear								6-5-65	
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial				New Cathedral Cem. Balto. Md					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUN 11 1965		Robert E. Johnson		Selma Perry 5646 Carroll Ave					

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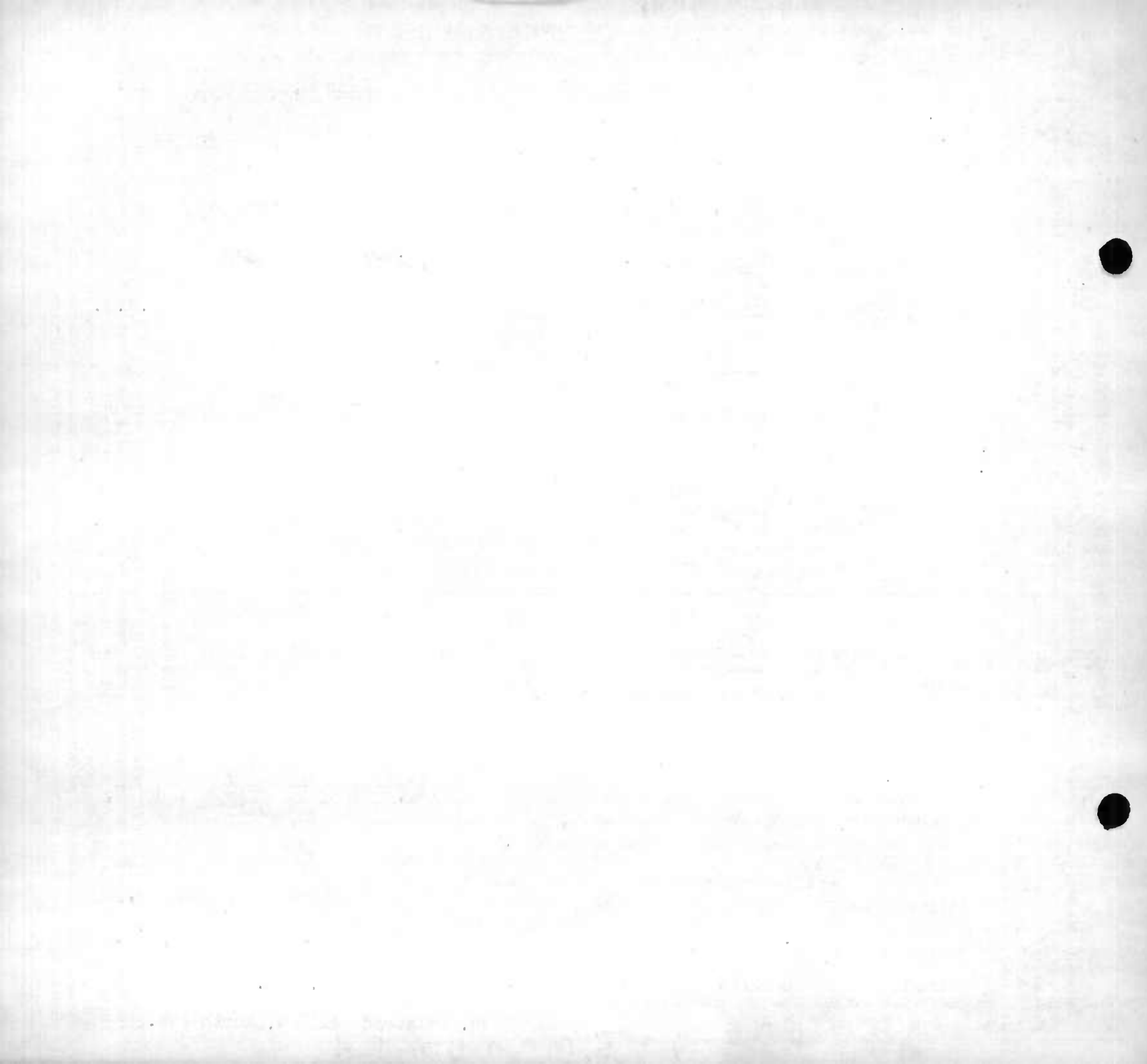
1963

WALSH & COMPANY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

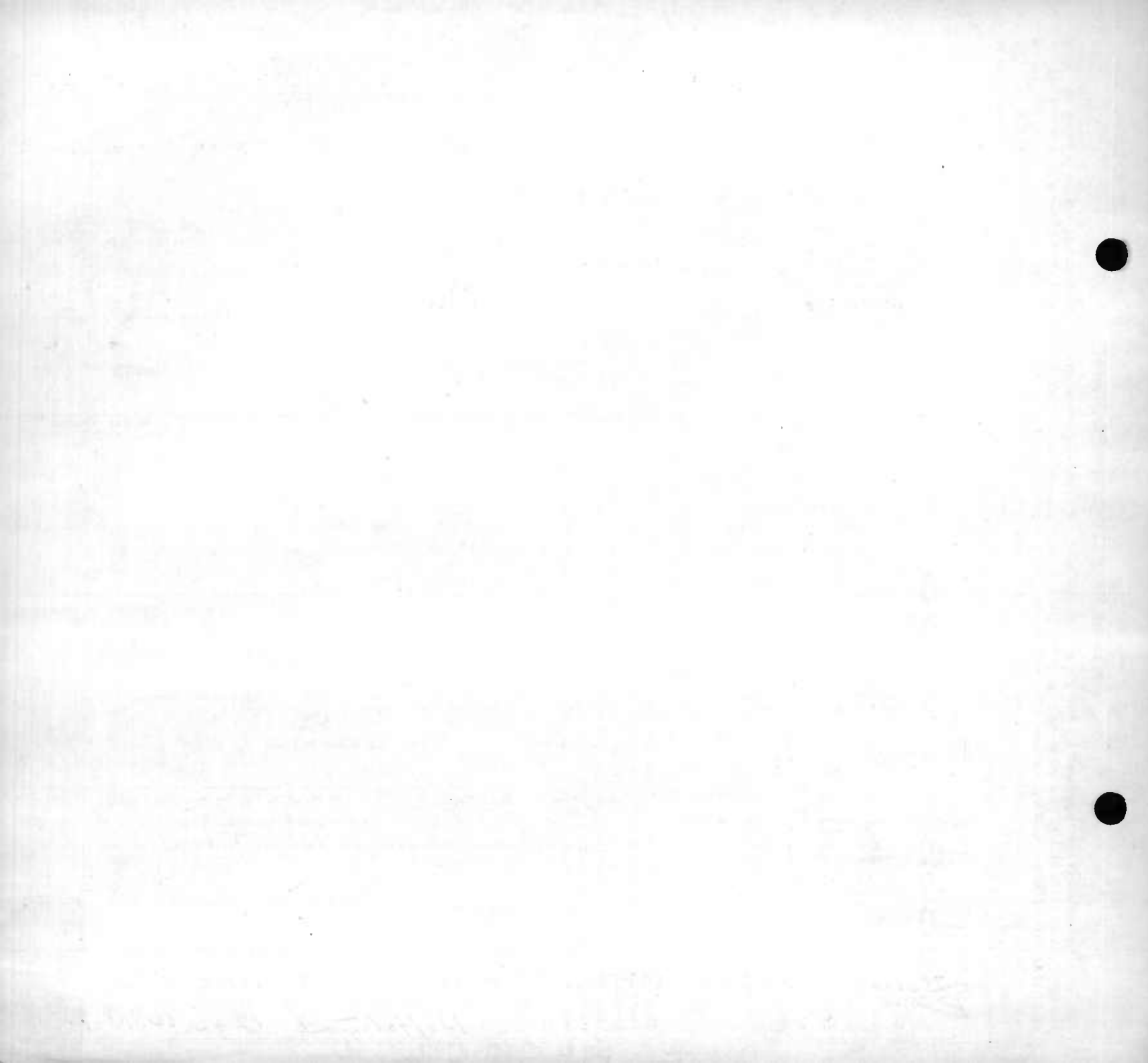
BIRTH NO. 65 6106				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6106	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Augustus Jones				June 8, 1965 11:45 a M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Provident Hospital 1514 Division St. Baltimore, Maryland 21217				Maryland 14-01			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				1703 Linden Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
Male	Negro	widowed	May 20, 1897	68			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
None			Maryland		U.S.A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
					Dorothy Ross-landlady same		
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) Uremia with shock			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				DUE TO 2 days			
ANTECEDENT CAUSES				(B) Urethral strictures and prostatic hypertrophy			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO several years			
(C)							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from May 20, 1965 to June 8, 1965, that (I) (we) last saw the deceased alive on June 8, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
M.Y. Ahmed						June 9, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
M.Y. Ahmed				M.D. 1514 Division St. Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/12/65		New Cathedral Cemetery		Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 11 1965		A. Halstead		A. Halstead		1206 W. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6107		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6107	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		PRISCILLA HENDERSON		6/10/65 4 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
#6 LUTHERAN HOSP.			Md. Balt.		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			Baltimore 53-00		
D. STREET ADDRESS (If rural, give location)			8 Jones Ave		
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
FEMALE		NEGRO		MARRIED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Housewife				6/8/14	
11. BIRTHPLACE (State or foreign country)		9. AGE (In years last birthday)		If Under 1 Yr. Months Days Hours Min.	
Md		51		If Under 24 Hrs. Min.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		?		?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				chart	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) ACUTE PULMONARY EDEMA DUE TO (B) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6/10 19 65 to 6/10 19 65, that (I) (we) last saw the deceased alive on 6/10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Oscar Fernandini				6/10/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
OSCAR FERNANDINI				LUTHERAN HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-13-65		Western Star Cem.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
Catonsville Md.		JUN 11 1965		Robert E. Farber	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. ADDRESS	
A. Halstead		1206 W. North Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6108	
BIRTH NO. 65 6108		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Esau Taylor</i>		2. DATE AND HOUR OF DEATH <i>6-8-65 11:30</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE <i>md</i> B. COUNTY <i>16-04</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto</i>		D. STREET ADDRESS (If rural, give location) <i>1000 N. Monroe St</i>	
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>7-7-08</i>	9. AGE (In years lost birthday) <i>57</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>British West Indies</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Chart</i>	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>181.0</i>		CAUSE OF DEATH (A) DUE TO <i>Squamous Cell Carcinoma of the bladder</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>4 mos</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Hypertension</i>		<i>unknown</i>	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <i>6/8 6/13 1965</i> to <i>6/8 1965</i> , that we (we) last saw the deceased alive on <i>6/8 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>R. G. Shugarman</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/8/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>R. G. Shugarman</i>		23D. ADDRESS <i>Sinai Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/12/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Calvary Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>A A County Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 11 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>Adolphus Halstead</i>	
				ADDRESS <i>918 Druid Hill Ave</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6109				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6109	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Willy Henry</u>				2. DATE AND HOUR OF DEATH <u>6/6/65</u> <u>17:45</u> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>18-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 21201</u> D. STREET ADDRESS (If rural, give location) <u>816 W. Mulberry St.</u>			
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6/4/83</u>	9. AGE (In years, last birthday) <u>82</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Shipping</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unk.</u>				16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Hospital chart</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Adenocarcinoma of stomach</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year?</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cerebrovascular accident, Arteriosclerosis 1 day</u>							
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Cerebrovascular accident, Arteriosclerosis 1 day</u>							
19A. DATE OF OPERATION <u>5/17/65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cancer of stomach</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (A) (this hospital) attended the deceased from <u>4/27 1965</u> to <u>6/6 1965</u> , that (I) (we) last saw the deceased alive on <u>6/6 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Peter E. MacMurray</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/6/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Peter E. MacMurray</u>				M.D. <u>University Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/11/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 11 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Falek</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u>		ADDRESS <u>918 Druid Hill Ave</u>	

University Hospital

Mr C Williams
Zephaniah Williams

Wm

Harriet Clark

Mr W Williams
Baltimore

10/12

Williams

Robert Williams

Robert Williams

12/10/12

Robert Williams

University Hospital

10/12

10/12

10/12

10/12

CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

2. DATE AND HOUR OF DEATH

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5. SEX

6. RACE

7. MARRIED NEVER MARRIED
WIDOWED DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years lost birthday)

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 200.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/14/65 1965 to 6/7/65 1965, that (I) (we) last saw the deceased alive on 6/7/65 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

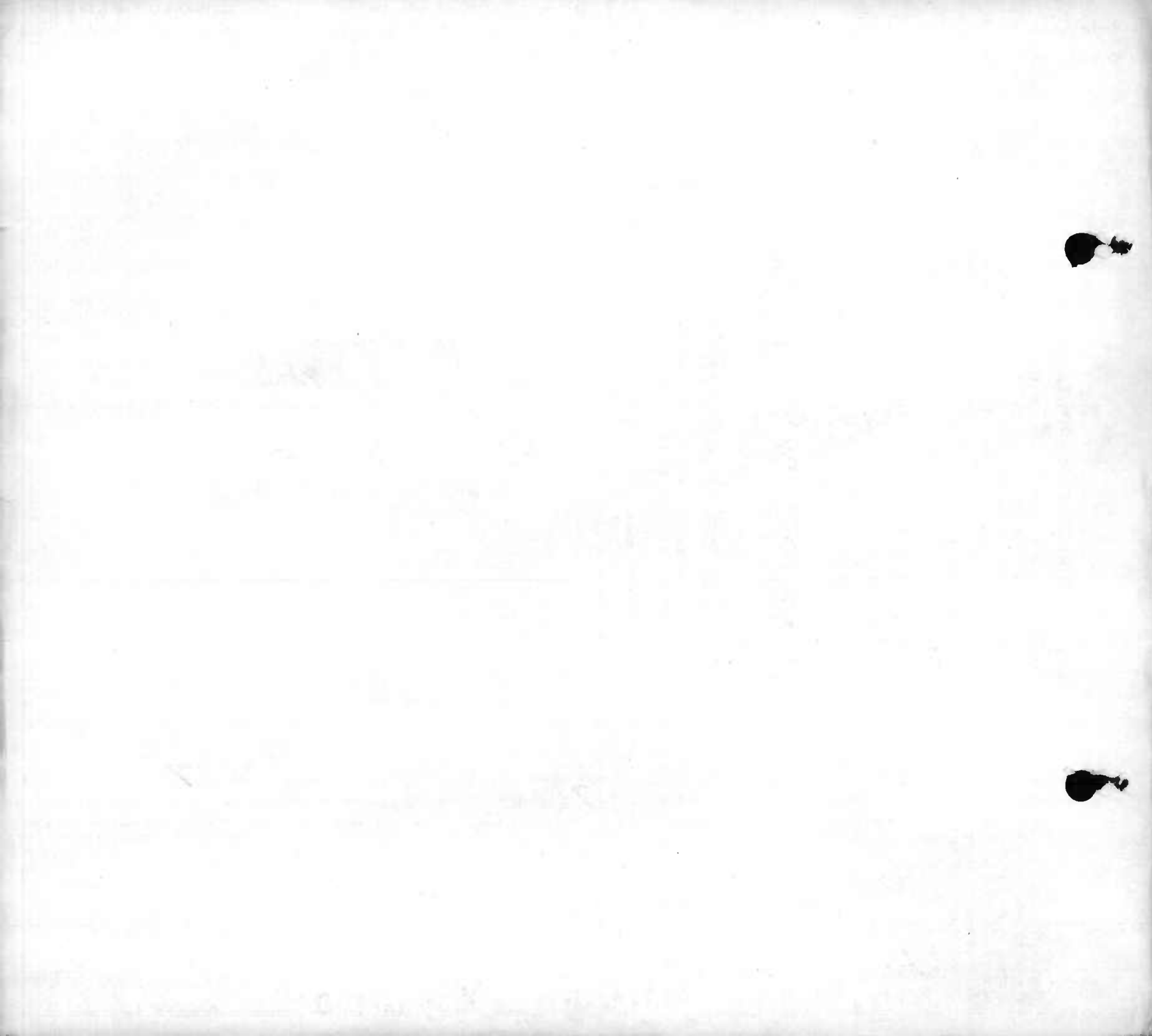
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6111				BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
M.E. CASE NO.				6-9-65		19.25 A. M.	
1. NAME OF DECEASED (Type or Print) <u>Raymond Genter -</u>				2. DATE AND HOUR OF DEATH			
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto. Md. 53-00</u>			
				D. STREET ADDRESS (If rural, give location) <u>1213 Lime Kiln Road -</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED <input type="checkbox"/> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>6-9-14</u>	9. AGE (In years lost birthday) <u>51</u>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Aero. engr.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Aero-Space</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md -</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Genter -</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Fliter</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-07-8430</u>		17. INFORMANT ADDRESS <u>Mrs. Wilma Genter 1213 Lime Kiln Rd. Towson, Maryland 21204</u>			
18. <u>331X I</u> CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>C U A</u>				(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Generalized arteriosclerosis</u>				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>0-0-0</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>no</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>no</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4-18-1965</u> to <u>6-9-1965</u> that (I) (we) last saw the deceased alive on <u>6-9-1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Fernando Juliao</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6-9-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>FERNANDO JULIAO</u>				23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-12-1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Trinity Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Elkridge Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 11 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Towson 1050 York Road Towson, Md. 21204</u>			

APR-30-1964

APR 30 1964

APR 30 1964

FUNERAL DIRECTOR: IMPORTANT

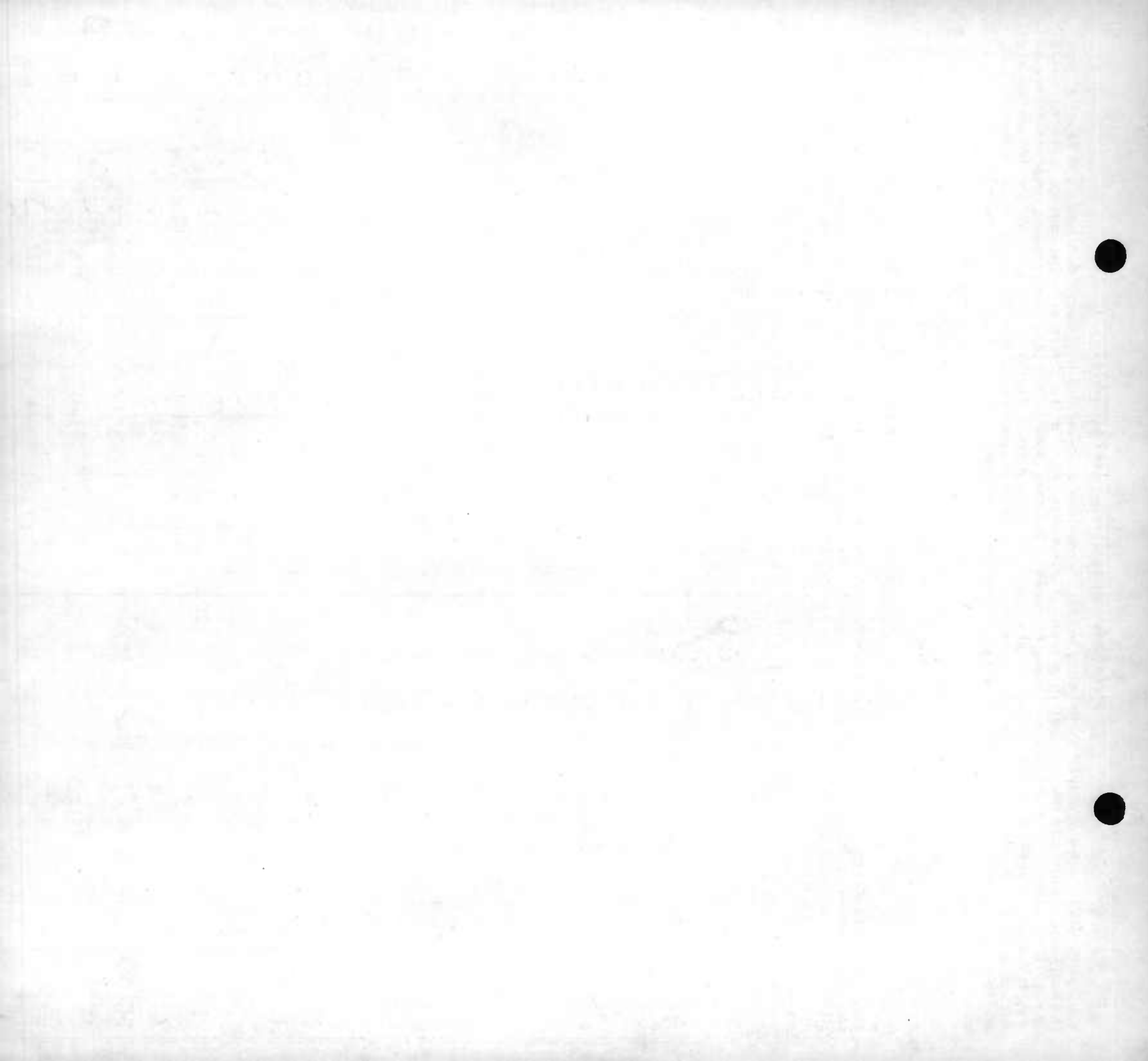
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 6112	
BIRTH NO. 65 6112		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				BOWLING, LORETTA E.		June 8, 1965 4:35 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
St. Joseph Hospital				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore,			
				D. STREET ADDRESS (If rural, give location)			
				2911 Dillon Street - 21224			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 7-6-07	9. AGE (In years lost birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Clerical		U.S. Fidelity & Guarantee		Baltimore, Md.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Thomas E. Bowling				Mary L. Murphy			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		215-07-8420		ST. Joseph Hosp., 1400 N. Caroline St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) Carcinomatosis			
ANTECEDENT CAUSES				(B) Carcinoma of breast.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				None			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from May 1, 19 65 to June 8, 19 65, that (I) (we) last saw the deceased alive on June 8, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Teodoro R. Carangal M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						June 8, 1965.	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Teodoro R. Carangal M.D.				1400 N. Caroline Street - 21213			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/10/65		New Cathedral Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 11 1965		Robert E. Fickens		NICHOLAS T. MATTHEWS		3021 Eastern Ave., Baltimore, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6113	
BIRTH NO. 65 6113		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GILDEN SARAH		2. DATE AND HOUR OF DEATH 6/9/65 - 11:16 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where Deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 15-09		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4 SINAI HOSPITAL, BALTIMORE		D. STREET ADDRESS (If rural, give location) 3112 GARRISON BLVD, #16			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W/dow	8. DATE OF BIRTH	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) RUSSIA	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME MELVIN		14. MOTHER'S MAIDEN NAME FAYE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS MRS. EDITH SHOCKET - Daughter		
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) - Chronic taacute Pulmonary Embolism - SHOCK (B) DUE TO ASCVD (C)			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/3/1965 to 6/9/1965, that (I) (we) last saw the deceased alive on 6/9/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Peter A. Papastamou M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 6/9/65	
23C. PHYSICIAN'S NAME (Type) M.D. SINAI HOSPITAL, BALTIMORE					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/10/1965	24C. NAME of CEMETERY or CREMATORY Rosehill	24D. LOCATION (City, town, or county) (State) Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1965	25B. NAME OF REGISTRAR Robert E. Farkas	25C. FUNERAL DIRECTOR ADDRESS SYLVAN S. LEWIS & SON, INC. 3319 OLYMPIA AVE			



FUNERAL DIRECTOR: IMPORTANT

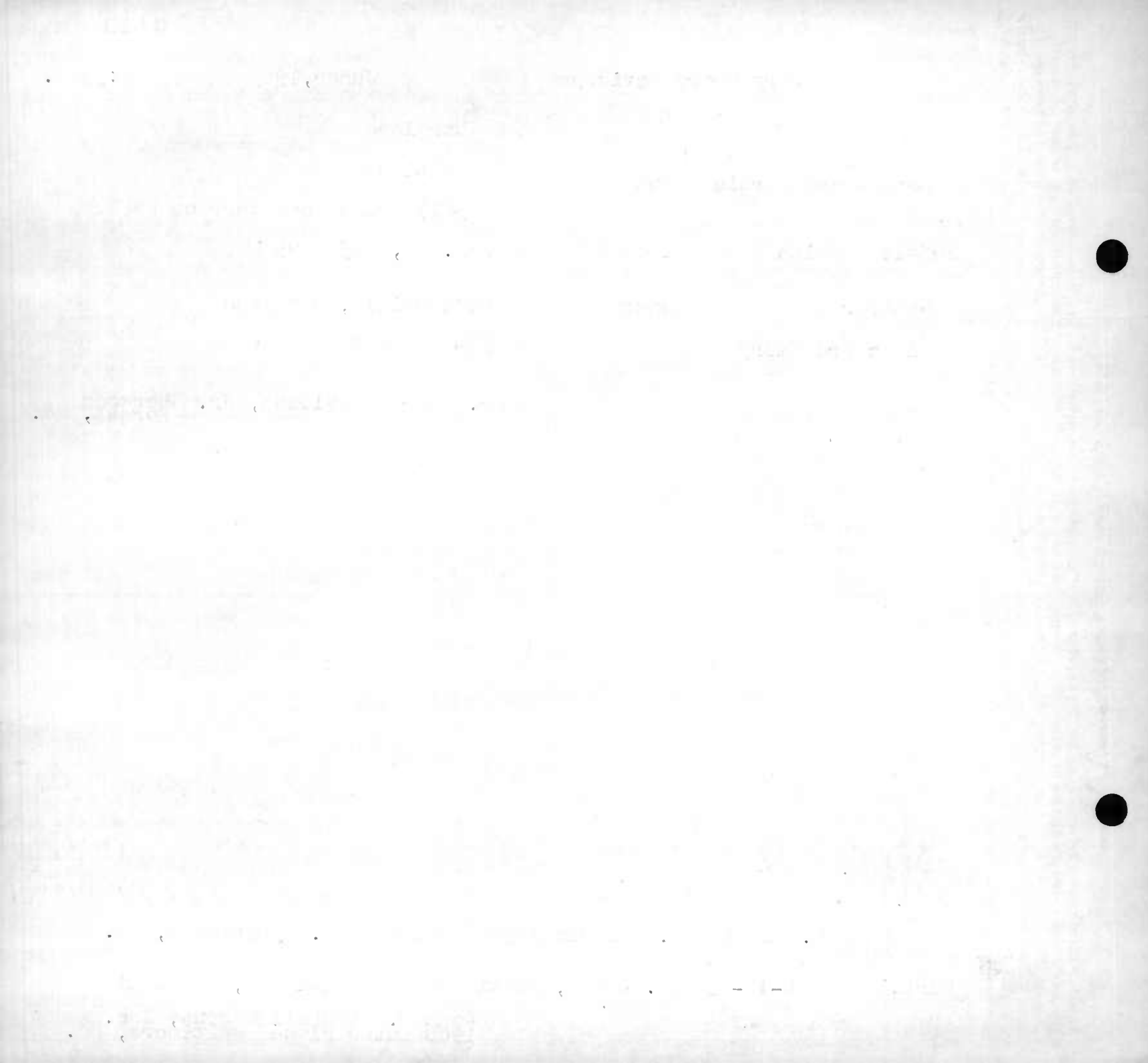
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6114		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 6114	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MARSHALL GARRETT BROWN			2. DATE AND HOUR OF DEATH 6-8-65 6:55P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL, WILKENS & CATON AVE BALTIMORE MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-04 C. CITY OR TOWN BALTIMORE D. STREET ADDRESS (If rural, give location) 602 ARSON AVE EXXO #25		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-30-84	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) TENNESSEE	
13. FATHER'S NAME Marshall Brown			14. MOTHER'S MAIDEN NAME unk.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST AGNES HOSPITAL RECORDS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiovascular Accident ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Brain Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-23 19 65 to 6-8- 19 65 , that (I) (we) lost saw the deceased alive on 6-8- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Pedro F. Bajo				23B. DATE SIGNED 6-8-65	
23C. PHYSICIAN'S NAME (Type) PEDRO F. BAJO				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-11-65		24C. NAME OF CEMETERY or CREMATORY Glenn Haven	
24D. LOCATION 6 Len Carme, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 11 1965			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS McGully Funeral Hn 237 Potomac Ave			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

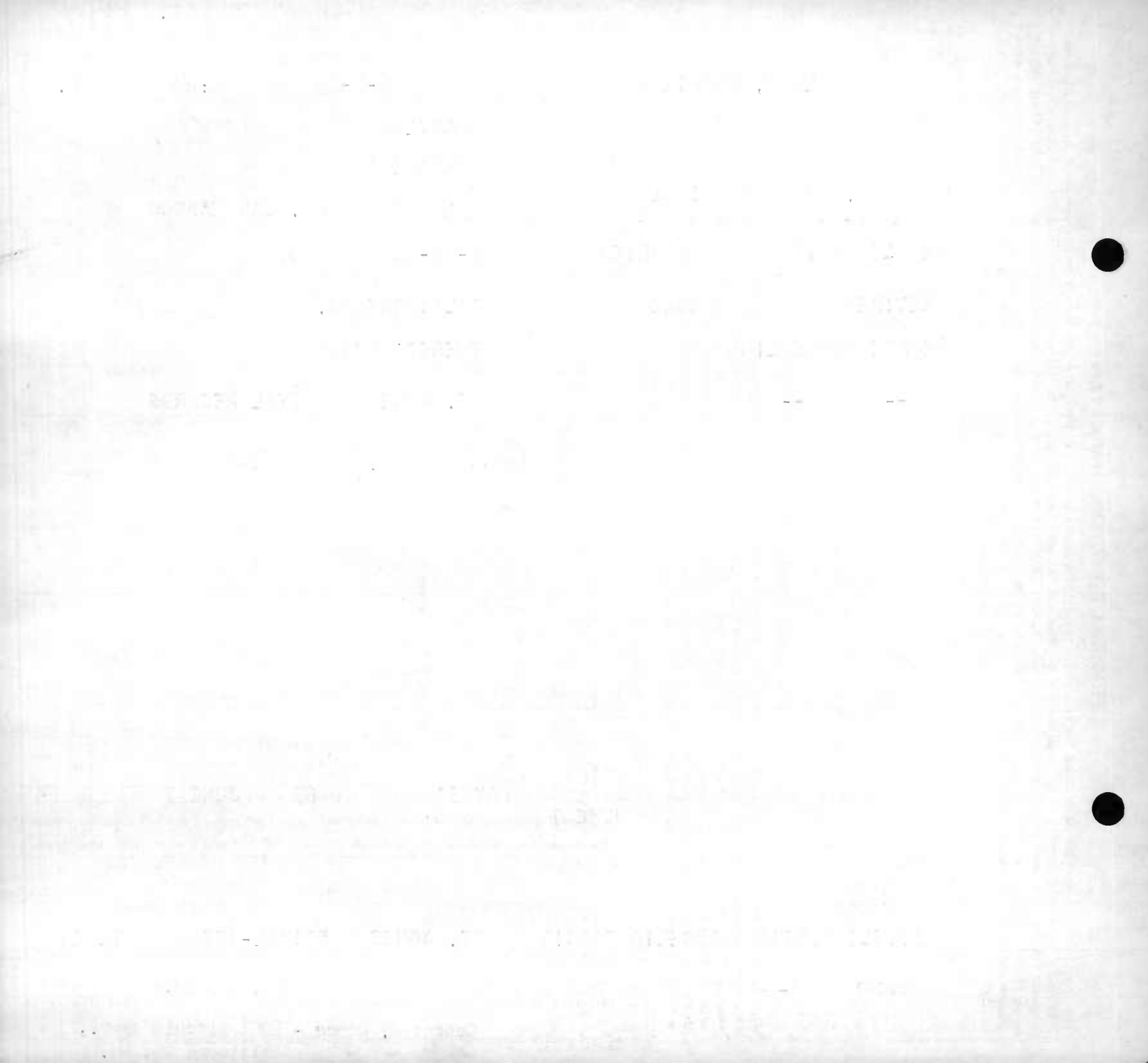
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 6115		CERTIFICATE OF DEATH		Registered No. 65 6115	
1. NAME OF DECEASED Mary Emory Davidson				2. DATE AND HOUR OF DEATH June 8, 1965		8:55 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Long Green Nursing Home				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 27-13				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH Aug. 30, 1865	9. AGE (In years and months) 99	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caterer		10B. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (State or foreign country) Centerville, Maryland		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Blanchard Emory				14. MOTHER'S MAIDEN NAME Mary Bourke					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. George Davidson, Jr.		ADDRESS Sherwood Forest, Md.			
18. 450.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Feb 1 19 65 to June 8 19 65 , that (I) (we) last saw the deceased alive on June 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE William G. Helfrich				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/8/65			
23C. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich				23D. ADDRESS 5006 Roland Ave. Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-11-65		24C. NAME OF CEMETERY or CREMATORY St. Johns, Huntingdon		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John O. Mitchell & Sons, Inc.		ADDRESS 1900 Eutaw Place Baltimore, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

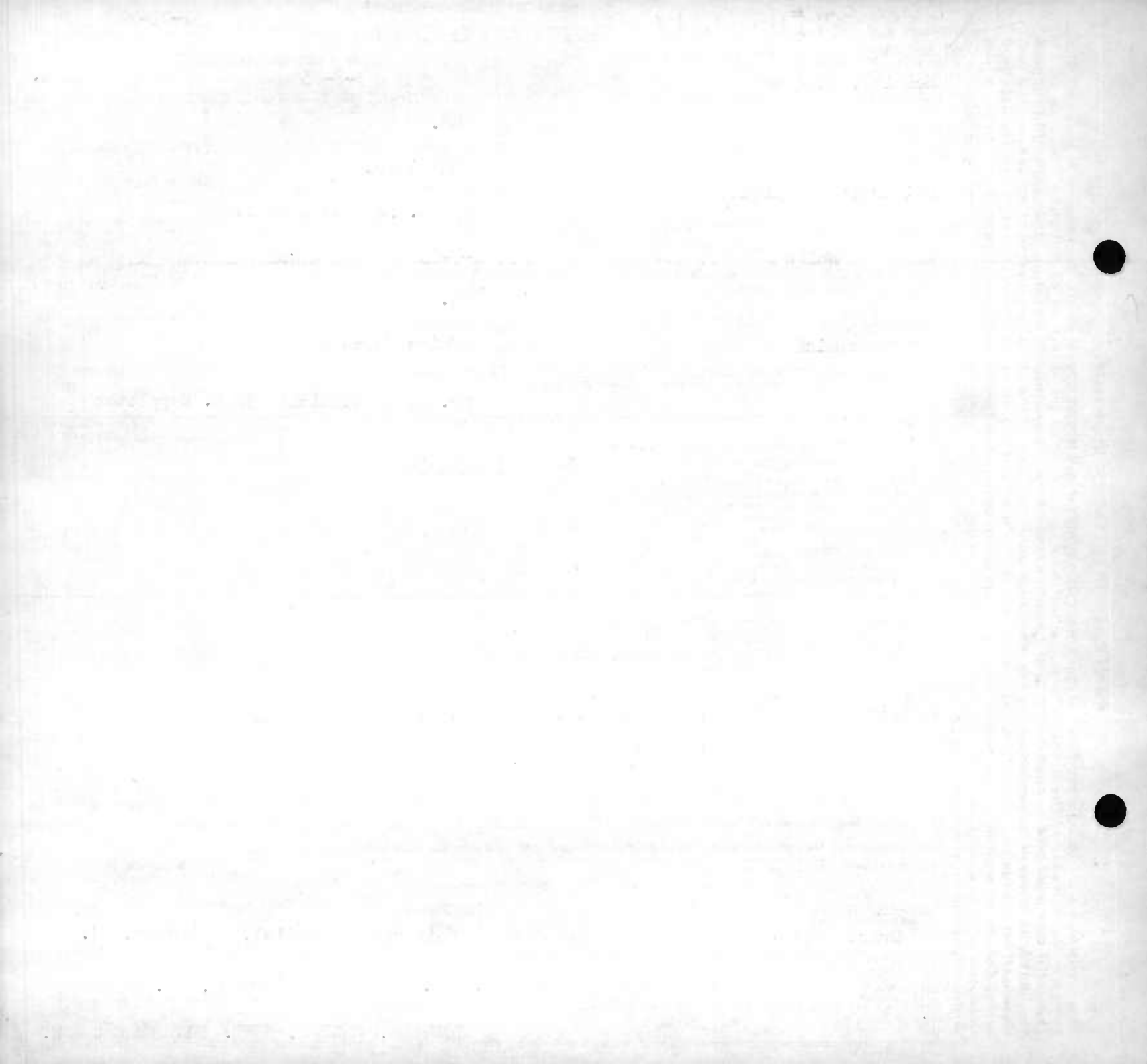
BIRTH NO. 65 6116				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6116	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print)				6-7-65 5:40 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
ST. AGNES HOSPITAL WILKENS & CATON AVES				MARYLAND			
5. SEX				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
FEMALE WHITE				PASADENA			
6. RACE				D. STREET ADDRESS (If rural, give location)			
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				32 JOHNSON RD. BAR HARBOR			
MARRIED				8. DATE OF BIRTH			
3-19-98				9. AGE (In years lost birthday)			
67				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
BALTIMORE MD.				U S A			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
GEORGE SCHEMEHLING				THERESA MYERS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
-- --				17. INFORMANT ADDRESS			
ST. AGNES HOSPITAL RECORDS							
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) Cerebro-Vascular Accident DUE TO (B) C.V.A. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION				20A. AUTOPSY? (Yes or No)			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from MAY 31 19 65 to JUNE 7 19 65, that (I) (we) last saw the deceased alive on JUNE 7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
ANGELIO GARCIA							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
ANGELIO GARCIA				ST. AGNES HOSPITAL-CATON & WILKENS			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				6-9-1965			
24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Loudon Park Cemetery				Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
JUN 11 1965				Robert E. Farber M.D.			
25C. FUNERAL DIRECTOR				ADDRESS			
George J. Gonce - 4001 Ritchie Hwy.,				Baltimore 25, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 31-02-27 65 6117	
BIRTH NO. 65-11214 65 6117 M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Helmick, Baby Boy				2. DATE AND HOUR OF DEATH 5-8-65 11 a. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND UNIVERSITY HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 18-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 32 S. Poppleton Street			
5. SEX M		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 5-7-65	
9. AGE (In years lost birthday) 1 day		10. CITIZEN OF WHAT COUNTRY?		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Gary Helmick				14. MOTHER'S MAIDEN NAME Louise Holehan			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Gerry Helmick	
				ADDRESS 32 S. Poppleton			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Immunaturity ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-7-65 to 5-8-65, that (I) (we) last saw the deceased alive on 5/8-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Grace Ayuyao</i>				23B. DATE SIGNED 5-8-65			
23C. PHYSICIAN'S NAME (Type) Grace Ayuyao				23D. ADDRESS University Hospital, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/10/65		24C. NAME OF CEMETERY or CREMATORY Glen Haven Mem. Pk.		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1965		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR JOHN F. DENNY, INC.		ADDRESS 715 Light St.	



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY

MAKS

2. DATE AND HOUR PRONOUNCED DEAD

June 9, 1965

8:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

BALTIMORE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore CATONSVILLE 5300

D. STREET ADDRESS (If rural, give location)

6000 Sherrill Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

Feb 22, 1892

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SEAMSTRESS

10B. KIND OF BUSINESS OR INDUSTRY

Tailoring

11. BIRTHPLACE (State or foreign country)

Hungary

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Iringer

14. MOTHER'S MARRIED NAME

Barbara Bohn

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

none.

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

Nina Hickman 6000 Sherrill Road

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/9/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

6-12-65

23C. NAME of CEMETERY or CREMATORY

New Cathedral

23D. LOCATION (City, town, or county) (State)

BALTIMORE, Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 11 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Geo. L. Schwab Funeral Home
Francis D. Miller 2101 Rudinck Ave.

ADDRESS

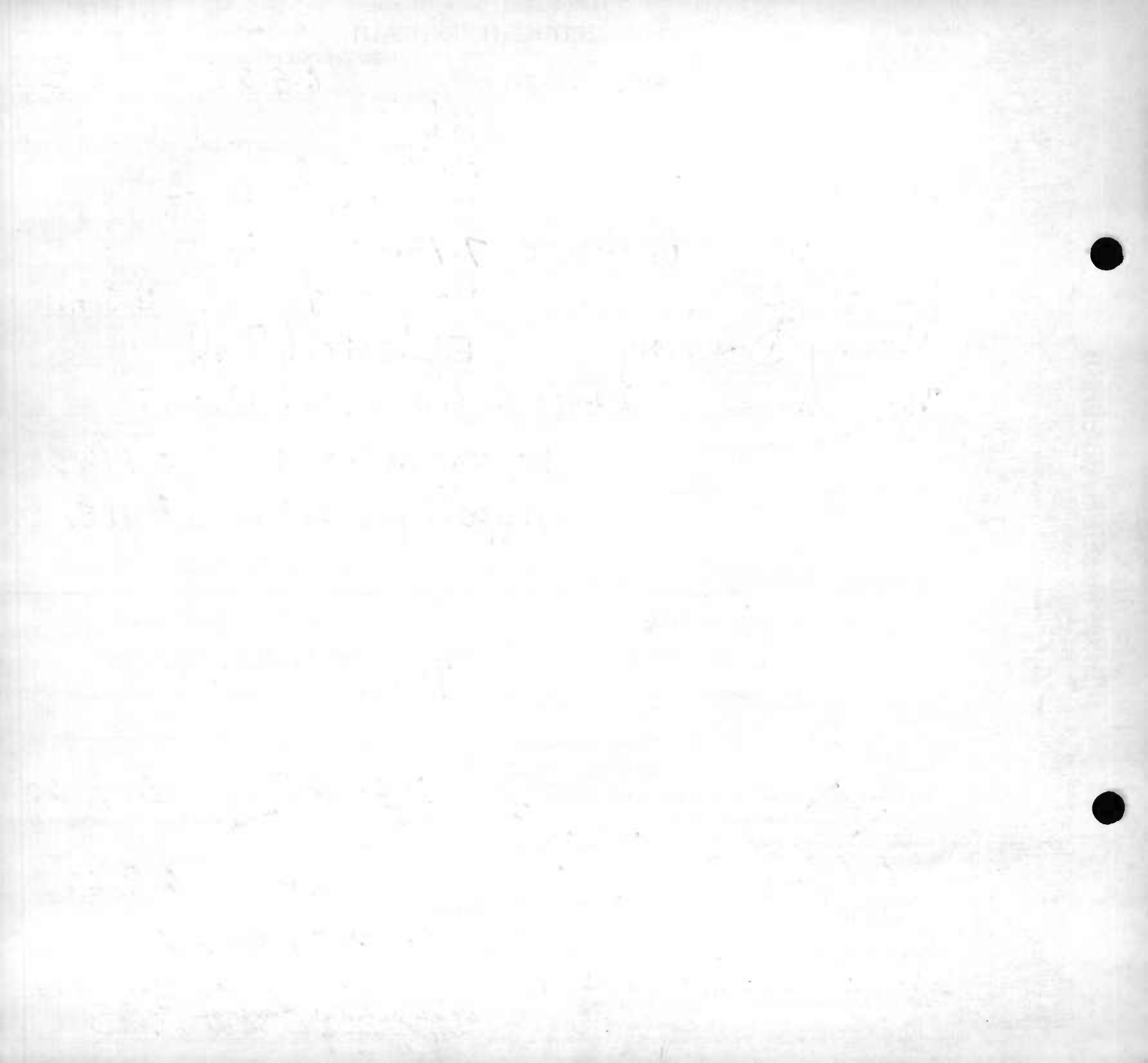
WALLEY & JOHNSON

CLARK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

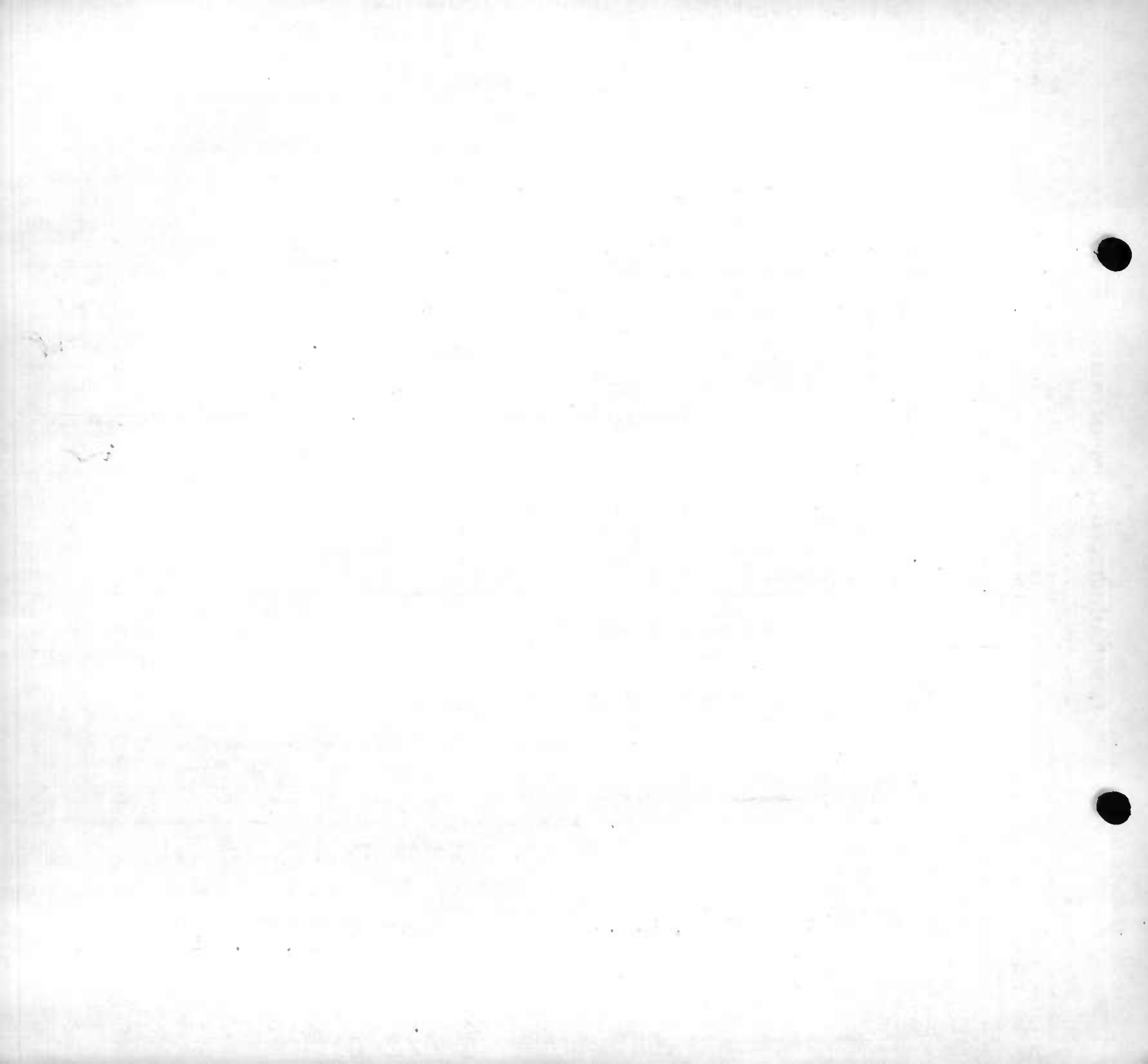
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 6119		CERTIFICATE OF DEATH		65 6119	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Carback, Anna Ellen		6.9.65 8 ⁵⁰ A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
University Hospital		Md. 19-04			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		1712 W. Pratt St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years, last birthday)	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
F	W	Widowed	7/13/00	64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife		Domestic	Maryland		U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Henry Doering		Elizabeth Doll			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No None		212-OS-7339D		Hospital Chart	
18. 253X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
		(A) Myxedema Coma DUE TO		24 hrs	
		(B) Hypothyroidism DUE TO		4 yrs.	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6.9.65 to 6.9.65, that (1) (we) last saw the deceased alive on 6.9.65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
[Signature]				6.9.65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		6-12-65		Loudon Park	
				BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 11 1965		Robert E. Farber, M.D.		Geo. L. Schwab Funeral Home 2101 Maryland Ave. R. H. Miller	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

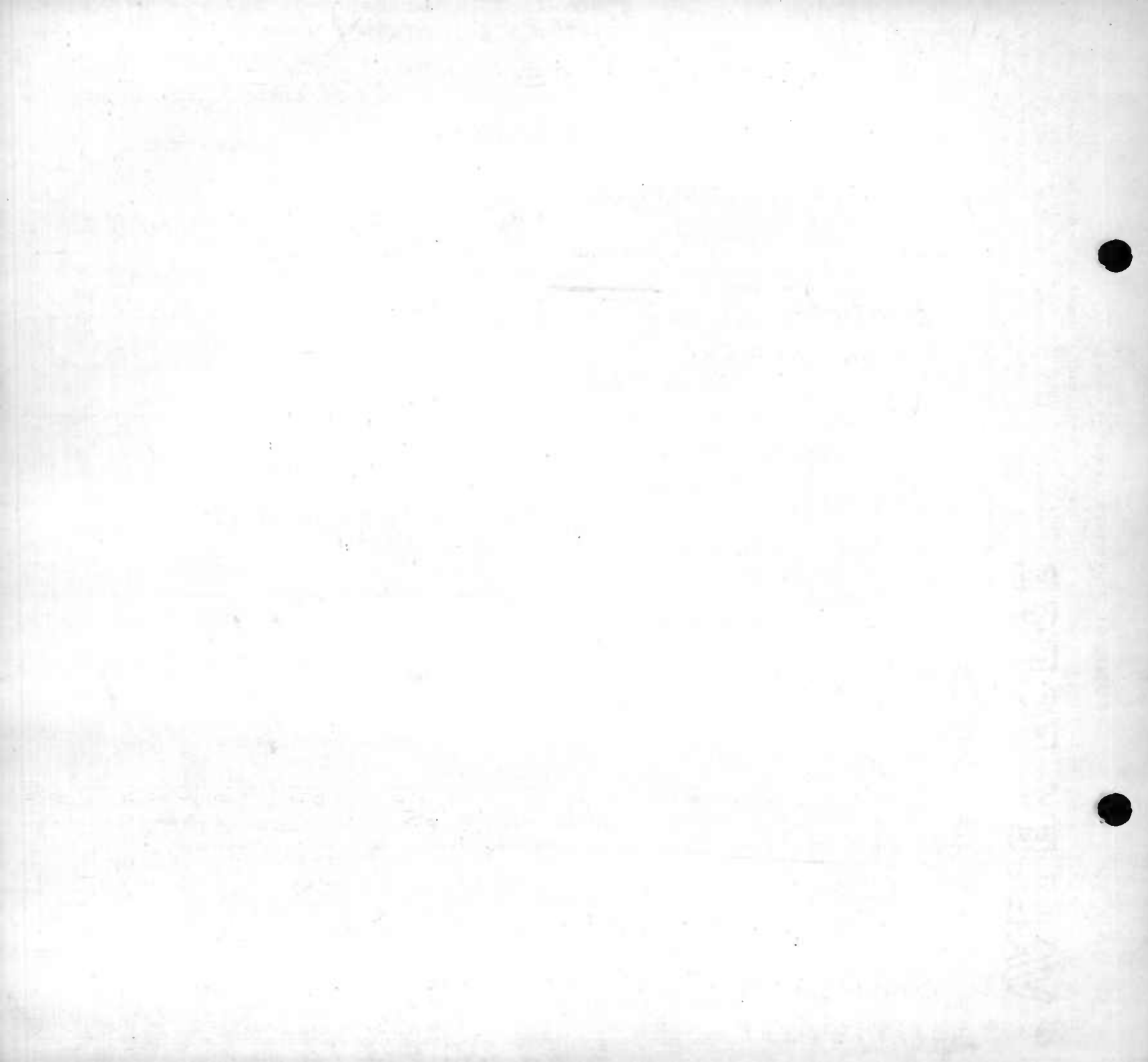
Baltimore City Health Department				Registered No. 65 6120	
Certificate of Death					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		ELIZABETH C. SKINNER		2. DATE AND HOUR OF DEATH 6-9-65 7 ^{PM} M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MD B. COUNTY 25-04			
CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE			
D. STREET ADDRESS (If rural, give location)		416 Pontiac Ave.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 6-4-84	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WM. HUBER		14. MOTHER'S MAIDEN NAME MARGARET	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Family	
18. CAUSE OF DEATH 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(A) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO		INTERVAL BETWEEN ONSET AND DEATH YEARS	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 2-20-64 19 to 6-5 1965, that (I) (we) last saw the deceased alive on 6-5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Luis Elias, M.D.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/10/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 203 Patapsco Avenue Baltimore, Md. 21225			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-11-65		24C. NAME of CEMETERY or CREMATORY Baltimore National Cem	
24D. LOCATION (City, town, or county) (State) Baltimore, Md		24E. DATE REC'D BY HEALTH DEPT. JUN 11 1965		24F. NAME OF REGISTRAR Robert E. Fink	
24G. FUNERAL DIRECTOR McCully Funeral Home		24H. ADDRESS 237 Patapsco Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6121	
BIRTH NO. 65 6121		M.E. CASE NO.		1. NAME OF DECEASED MAYBELLE E HAYNIE	
2. DATE AND HOUR OF DEATH 6/10/65 4 40 A.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. SEX FEM			
A. STATE MD		6. RACE WHITE			
B. COUNTY BALTO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		8. DATE OF BIRTH 4/5/00			
D. STREET ADDRESS (If rural, give location) 404 Townsend Ave		9. AGE (In years lost birthday) 65			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME Charles Rebstock		14. MOTHER'S MAIDEN NAME DRUCILLA		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Chakt	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) CERE BRO VASCULAR AC - CIDENT			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) HYPERTENSIVE CARDIOVASCULAR DISEASE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/9/65 19 65 to 6/10/65 19 65, that (I) (we) last saw the deceased alive on 6/9 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Oscar Fernandez		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/10/65	
23C. PHYSICIAN'S NAME (Type) OSCAR FERNANDINI		23D. ADDRESS Lutheran Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-12-65		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cem	
24D. LOCATION (City, town, or county) Glen Burnie MD.					
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS McCully funeral Hm 23 Rtd 23	



BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
CALVIN E. HUBBARD				June 9, 1965 5:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
South Baltimore General Hospital				Maryland			
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
				Pasadena			
				D. STREET ADDRESS (If rural, give location)			
				Mountain Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
Male	White	Married	6-18-05	59			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Dispatcher		Baltimore Transit		Dorchester County, Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George W. Hubbard				Lula M. Wolford			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				Pasadena, Md.		Route #9	
				Mrs. Helen M. Hubbard-Mountain Rd.		Box 220	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Arteriosclerotic Cardiovascular Disease.			
				(B) DUE TO			
				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				Yes		Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I certify that I held an inquiry <input type="checkbox"/> inspection <input type="checkbox"/> autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		6/9/65	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		6-12-65		Glen Haven Memorial Park		Glen Burnie, Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS			
JUN 11 1965		Robert E. Farber		Howard H. Hubbard-4107 Wilkens Ave-21229			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6123	
BIRTH NO. 65 6123		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Berliners, Carrie Estelle</i>		2. DATE AND HOUR OF DEATH <i>6/9/65 12:20 P. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Montebello State Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>2-8-05</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>205 S. Farrow St.</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED NEVER MARRIED WIDOWED DIVORCED (specify)	8. DATE OF BIRTH <i>4/14/1895</i>	9. AGE (In years last birthday) <i>70</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>
13. FATHER'S NAME <i>John P. Manick</i>		14. MOTHER'S M maiden name <i>Mollie Thomas</i>		17. INFORMANT <i>P.O. Box 1871- Annapolis, Md.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>unknown</i>		17. ADDRESS <i>Miss Elizabeth Messick</i>	
18. <i>170 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying; e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) CAUSE OF DEATH <i>Adenocarcinoma of left Breast c metastasis</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/21/64</i> 19 to <i>6/9/65</i> 19, that (I) (we) last saw the deceased alive on <i>6/9/65</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Daniel G. Lai</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/9/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Daniel G. Lai</i>		23D. ADDRESS <i>2201 Argonne Drive, Baltimore, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-12-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Loudon Park</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 11 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>		25C. FUNERAL DIRECTOR <i>Howard H. Hubbard-4107 Wilkens Ave-21229</i>	



1877-1878

1877-1878

WALTON (1877-1878)

And J. Robinson

65 6124

BALTIMORE CITY HEALTH DEPARTMENT

65 6124

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BERTHA C. STEHL

2. DATE AND HOUR PRONOUNCED DEAD

June 8, 1965 6:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1017 Cathedral Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

2-25-85

9. AGE (In years
last birthday)

80

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Rudolph Lupus

14. MOTHER'S MAIDEN NAME

Amelia -

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Stewart Wade-640 Brisbane Rd. 21229

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/9/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-11-65

23C. NAME of CEMETERY or CREMATORY

Western

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 11 1965

Robert E. Fairbank

Howard H. Hubbard-4107 Wilkens Ave-21229

WALLEY PORRICE

WAS DRY

Clay

BIRTH NO.

65 6125

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 6125

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FREDERICK SCHUBERT

2. DATE AND HOUR PRONOUNCED DEAD

6-7-65

3:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3126 O'DONNELL STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3126 O'Donnell Street

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

Oct. 10, 1910

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Able-bodied seaman

10B. KIND OF BUSINESS OR INDUSTRY

Tug boats

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Charles Schubert

14. MOTHER'S MAIDEN NAME

Alberta Burke

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

212-10-1639

17. INFORMANT

ADDRESS

Mrs. Lillian Schubert - 3126 O'Donnell St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

6-7-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/11/65

23C. NAME of CEMETERY or CREMATOR

St. Stanislaus

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 11 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

George A. Weber - 705 S. Ann St. #21231

ADDRESS

14

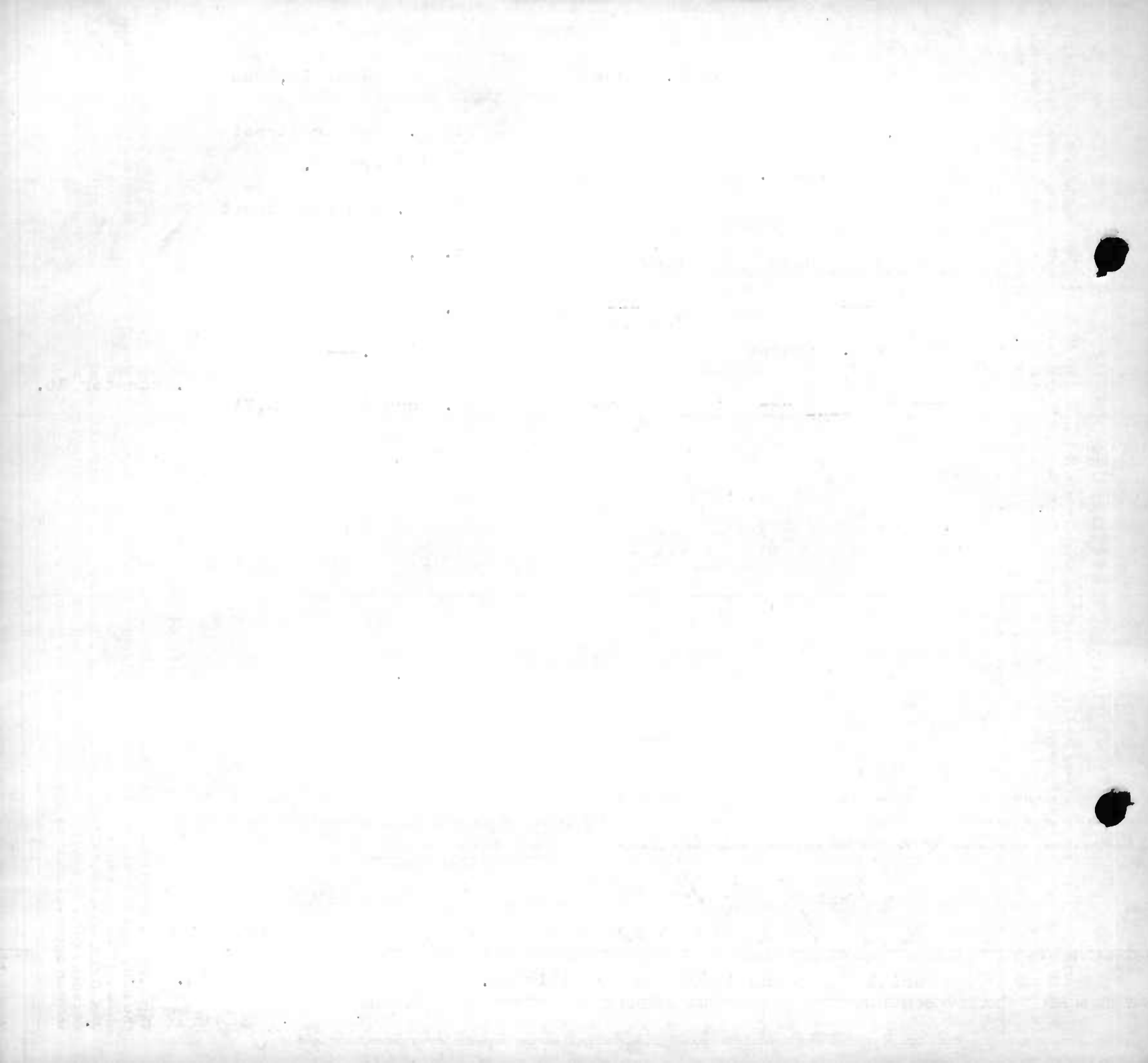
WALLACE
FORGE

Handwritten signature or initials, possibly "Hand WA".

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

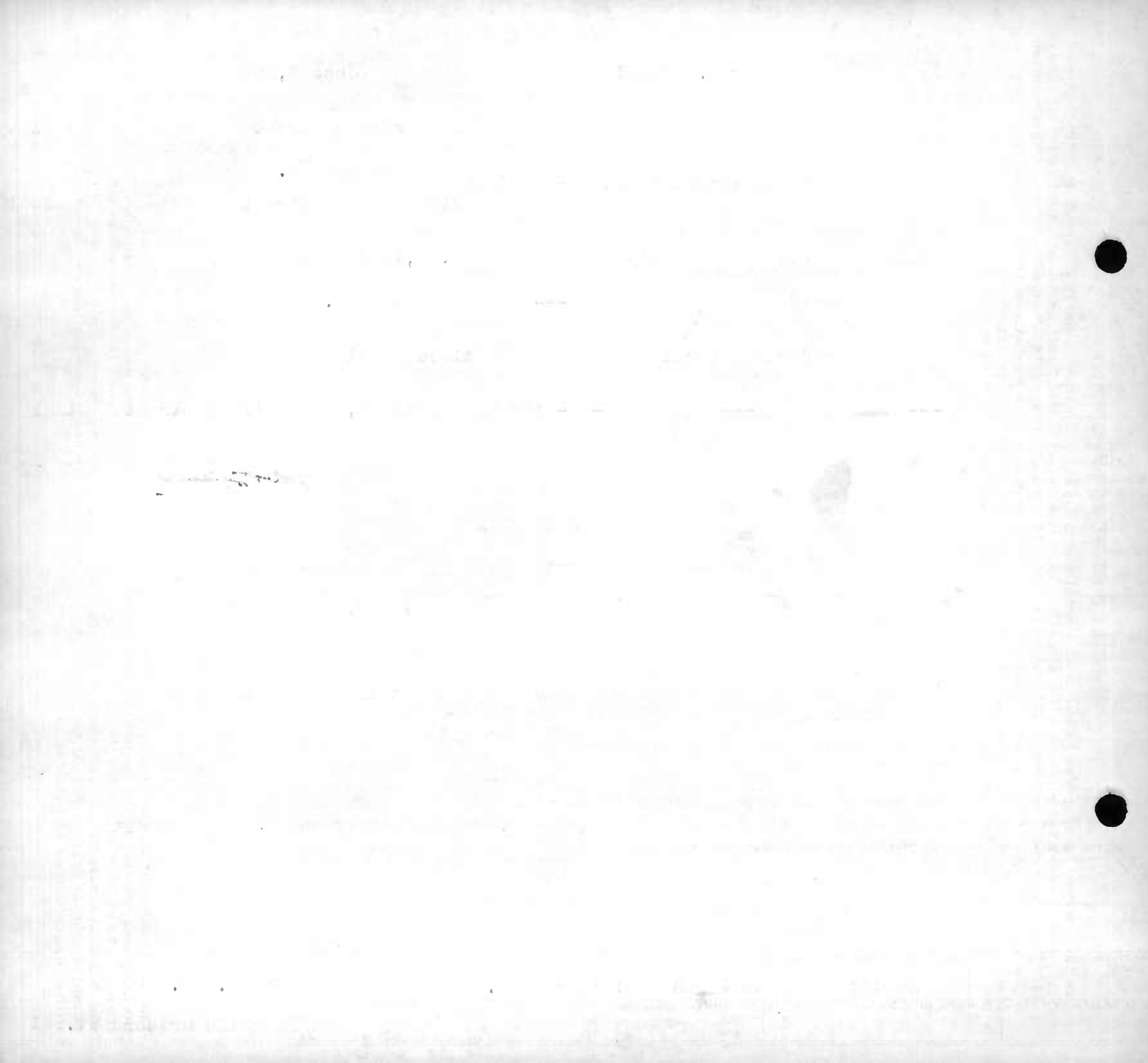
BALTIMORE CITY AND COUNTY				BIRTH NO. 65 6126		CERTIFICATE OF DEATH		Registered No. 65 6126	
1. NAME OF DECEASED (Type or Print) Annie V. Russell				2. DATE AND HOUR OF DEATH June 10, 1965					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 719 N. Chester Street				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 719 N. Chester Street C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Md. D. STREET ADDRESS (If rural, give location) 719 N. Chester Street					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Sept. 20, 1879	9. AGE (In years last birthday) 86	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---			10B. KIND OF BUSINESS OR INDUSTRY ---			11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Rodney S. Edwards			14. MOTHER'S MAIDEN NAME Annie V.---						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ---			16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS 719 N. Chester St. Mrs. Cornelia Dykman, 719				
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARCINOMA - LOWER BOWEL				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) ARTERIOSCL. HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR 2 years			
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 6-4-1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6-4-1965 to 6-10-65 19 65 , that (I) (we) last saw the deceased alive on 6/9/65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE BENJ. B. MOSES, M.D.				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/10/65			
23C. PHYSICIAN'S NAME (Type) BENJ. B. MOSES, M.D.				23D. ADDRESS 448 N. LUZERNE AVE. BALTO. MD					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 12/65		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cem.		24D. LOCATION (City, town, or county) (State) Balto. d.			
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1965		25B. NAME OF REGISTRAR Robert S. Taylor		25C. FUNERAL DIRECTOR Philip's New York		25D. ADDRESS 224 Orleans St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

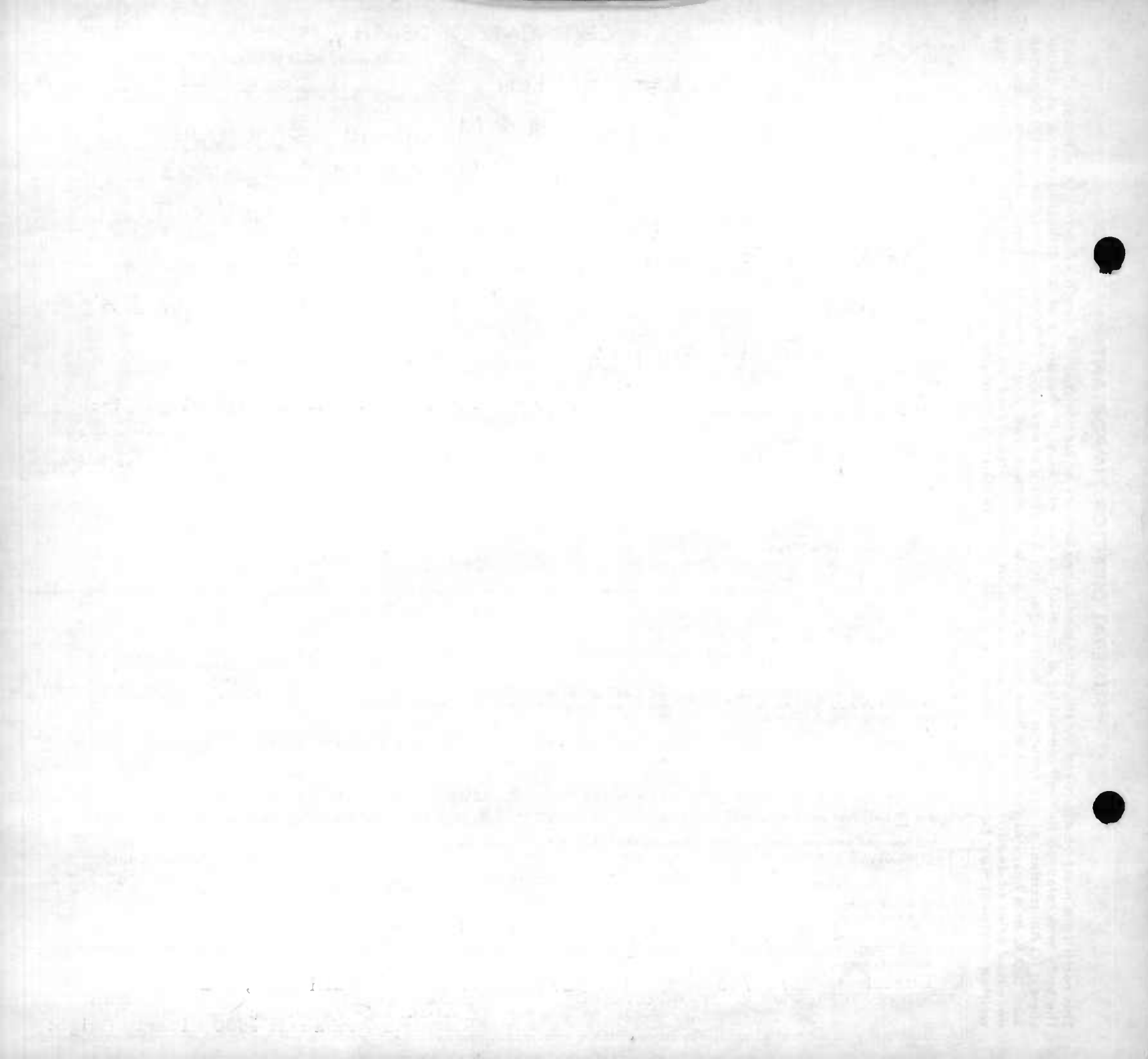
BIRTH NO. 65 6127		BALTIMORE CITY HEALTH DEPARTMENT		65 6127	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) Edgar M. Ditzel			2. DATE AND HOUR OF DEATH June 8, 1965		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 2132 Orleans Street -31			A. STATE 2132 Orleans Street B. COUNTY 6-03 21231		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Md.		
			D. STREET ADDRESS (If rural, give location) 2132 Orleans Street 21231		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Aug. 30, 1898	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10B. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Frederick Ditzel			14. MOTHER'S MAIDEN NAME Alice Bellis		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. 213-20-0198	17. INFORMANT Verna Ditzel, 2132 Orleans Street 21231		
18. 148X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Congestive Heart Failure DUE TO (B) Metastatic Carcinoma DUE TO (C) (Primary Site Unknown) Entirely Unknown Acute Manicosis INTERVAL BETWEEN ONSET AND DEATH 2 Days					
19. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1 - 1965 to June 8 - 1965 , that (I) was last saw the deceased alive on June 8 - 1965 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) Was (did not) view the body after death. Yes					
23A. SIGNATURE Wm. G. Geyer		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/11/65	
23C. PHYSICIAN'S NAME (Type) WM. G. GEYER		23D. ADDRESS 156 N. Milton Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE June 11/65	24C. NAME OF CEMETERY or CREMATORY Baltimore Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Philip H. Wriggins	
				ADDRESS 2124 Orleans St. 31	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6128	
BIRTH NO. 65 6128		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Mrs. Olivia C. Rhoten		10 June 1965 5:05 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital		A. STATE B. COUNTY Maryland Baltimore	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21228 5300	
		D. STREET ADDRESS (If rural, give location) 6524 Woodbridge Circle	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11-19-10
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 54
13. FATHER'S NAME George F. Mayers		11. BIRTHPLACE (State or foreign country) Balt Co Maryland	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-26-2440	12. CITIZEN OF WHAT COUNTRY? U.S.A.
		14. MOTHER'S MAIDEN NAME Alverta Uhler	
		17. INFORMANT Kenneth Rhoten 6524 Woodbridge Circle	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
		(A) Recent Acute Myocardial Infarct 2 days	
		(B) Atherosclerotic Heart Disease years	
		(C) Pulmonary Emboli 2 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 6 19 65 to June 10 19 65, that (I) (we) lost saw the deceased alive on June 9 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Jose V. de Leon, Jr.		23B. DATE SIGNED 6-10-65	
23C. PHYSICIAN'S NAME (Type) JOSE V. DE LEON, JR.		23D. ADDRESS Bon Secours Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/14/65	
24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1965		25B. NAME OF REGISTRAR Robert E. Finkbeiner	
25C. FUNERAL DIRECTOR Ellsworth Armacost		25D. ADDRESS 4600 Liberty Heights	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6129		BALTIMORE CITY HEALTH DEPT.		Registered No. 65 6129	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) MEISER, JOHN E.		
2. DATE AND HOUR OF DEATH			JUNE 9, 1965 3:50 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
MARYLAND GEN. HOSPITAL			Maryland. 28-02		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			BALTIMORE		
D. STREET ADDRESS (If rural, give location)			5101 Liberty Heights Avenue		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	White	Married	7/5/13	51	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Owner - Club		Club Owner		Baltimore, Maryland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
JOHN B. MEISER			USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			215-09-2422		EDNA MEISER - 5101 Liberty Heights Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			UREMIC PNEUMONITIS		
ANTECEDENT CAUSES			(A) DUE TO		
			HEPATO-RENAL SYNDROME		
			(B) DUE TO		
			PORTAL CIRRHOSIS		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6-2 1965 to 6-9 1965, that (I) (we) last saw the deceased alive on 6-9-65 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Sabundayo, Rolando M.D.				Jun 9/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
SABUNDAYO, ROLANDO M.D.				Maryland Gen. Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/12/65		Woodlawn Cemetery	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 11 1965		Robert E. Fink		Ellsworth Armacost 4600 Liberty Heights	

L. V. 1000. 1000. 1000.

FUNERAL DIRECTOR: IMPORTANT

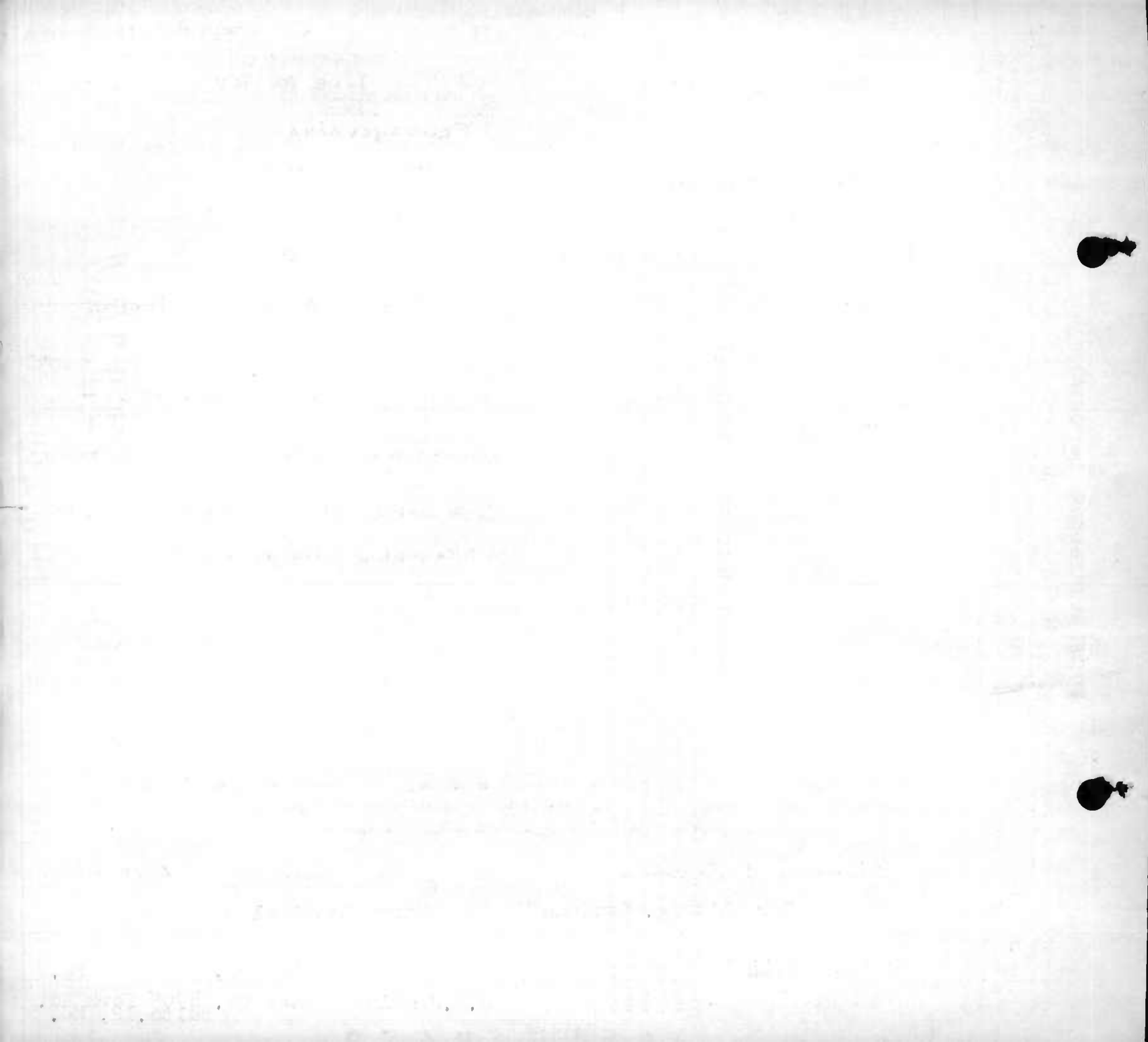
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6130	
BIRTH NO. 65 6130		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lida UMPLEBY		2. DATE AND HOUR OF DEATH June 9-1965 12³⁵ A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTO.			
FULL NAME OF HOSPITAL OR INSTITUTION Hospital for the Women of Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 34 Lyndale Ave.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Apr 2, 1883	9. AGE (In years last birthday) 82	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home
11. BIRTHPLACE (State or foreign country) ALLentown PA.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Wm. Henry ASH			14. MOTHER'S MAIDEN NAME Mary Jane Spang		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Miss Bron May Daughter of 34 Lyndale Ave
18. 204.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Acute Monocytic Leukemia		CAUSE OF DEATH (A) DUE TO Secondary Pulmonary Infection			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 2nd 1965 to JUNE 9th 1965 , that (I) (we) last saw the deceased alive on JUNE 8th 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED June 9th, 65	
23C. PHYSICIAN'S NAME (Type) STUART SUNDAY M.D.				23D. ADDRESS Alleganville Amaret 4600 Liberty Heights	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/12/65		24C. NAME OF CEMETERY or CREMATORY Cressona	
24D. LOCATION (City, town, or county) (State) Cressona Sch Co. Pa.		25A. DATE REC'D BY HEALTH DEPT. JUN 11 1965			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Alleganville Amaret 4600 Liberty Heights			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6131				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6131	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) RACHEL B. ARNOLD				2. DATE AND HOUR OF DEATH JUNE 10, 1965 6:05 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE PENNSYLVANIA B. COUNTY HARRISBURG C. CITY OR TOWN (If outside city limits, write RURAL and give township) HARRISBURG D. STREET ADDRESS (If rural, give location) 2251 Jefferson St.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 10-17-84	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA PENNSYLVANIA	
13. FATHER'S NAME EDWIN S. JONES				14. MOTHER'S MAIDEN NAME ANIE HILL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT LEWIS J. JONES		ADDRESS HOPKINS APTS.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 2 hrs. 2 yrs. 4 yrs.				INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 2 yrs. 4 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) —		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 6-5-65 19 to 6-10-65 19 that (H) (we) last saw the deceased alive on JUNE 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Carmelita A. Cendana M.D.				23B. DATE SIGNED 6-10-65		23C. PHYSICIAN'S NAME (Type) Carmelita A. Cendana M.D.	
23D. ADDRESS Mercy Hospital				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 6/11/1965		24C. NAME OF CEMETERY or CREMATORY Paxtang		24D. LOCATION (City, town, or county) (State) Harrisburg, Pa.		25A. DATE REC'D BY HEALTH DEPT. JUN 11 1965	
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25D. ADDRESS 4905 York Rd. Balto. 12, Md.		VS 150-REV. 1/1/65	



FUNERAL DIRECTOR: IMPORTANT

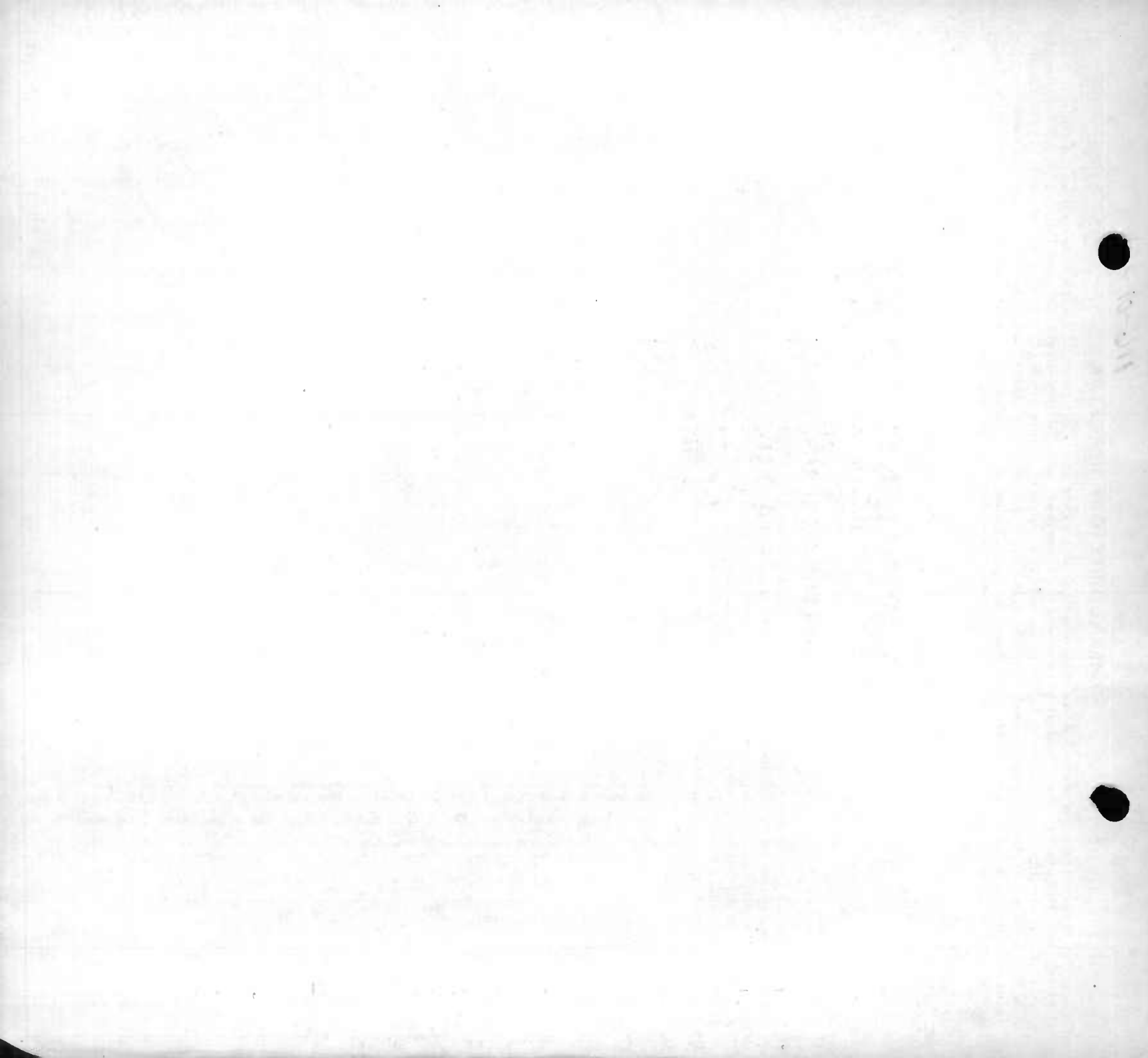
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6132	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. _____</p> <p>M.E. CASE NO. _____</p> <p>1. NAME OF DECEASED (Type or Print) BENEDICT, JOSEPH ANTHONY</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 6/10/65 11 A.M.</p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p>MARYLAND GENERAL HOSPITAL 827 LINDEN AVE BALTO 1, MD.</p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE MARYLAND B. COUNTY BALTO</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) RANDALLSTOWN 53-00</p> <p>D. STREET ADDRESS (If rural, give location) 3604 COURTLEIGH DR.</p>		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4/3/23	9. AGE (In years lost birthday) 42	10. If Under 1 Yr. Months: Days: Hours: Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHEMIST		10B. KIND OF BUSINESS OR INDUSTRY FOOD & DRUG		11. BIRTHPLACE (State or foreign country) KANSAS	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LOUIS BENEDICT		14. MOTHER'S MAIDEN NAME MARY MORRIS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. _____		17. INFORMANT ADDRESS MARYLAND GEN. HOSP. 827 LINDEN AVE.	
<p>18. 420.1 I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>ACUTE MYOCARDIAL INFARCTION ACUTE CORONARY THROMBOSIS ARTERIO SCLEROTIC HEART DISEASE</p>			<p>INTERVAL BETWEEN ONSET AND DEATH _____</p>		
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTAINING CAUSES OF DEATH? Yes		<p>(If in Baltimore City, give exact location)</p>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? _____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
<p>22. I certify that (I) (this hospital) attended the deceased from 6/7 19 65 to 6/10 19 65, that (I) (we) last saw the deceased alive on 6/10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
23A. SIGNATURE Pietro Lestur				23B. DATE SIGNED 6/10/65	
23C. PHYSICIAN'S NAME (Type) LASTRULLI PIETRO				23D. ADDRESS MARYLAND GENERAL HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/15/1965		24C. NAME OF CEMETERY or CREMATORY Arlington National	
24D. LOCATION Arlington		24E. (City, town, or county) Va.		24F. (State) _____	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

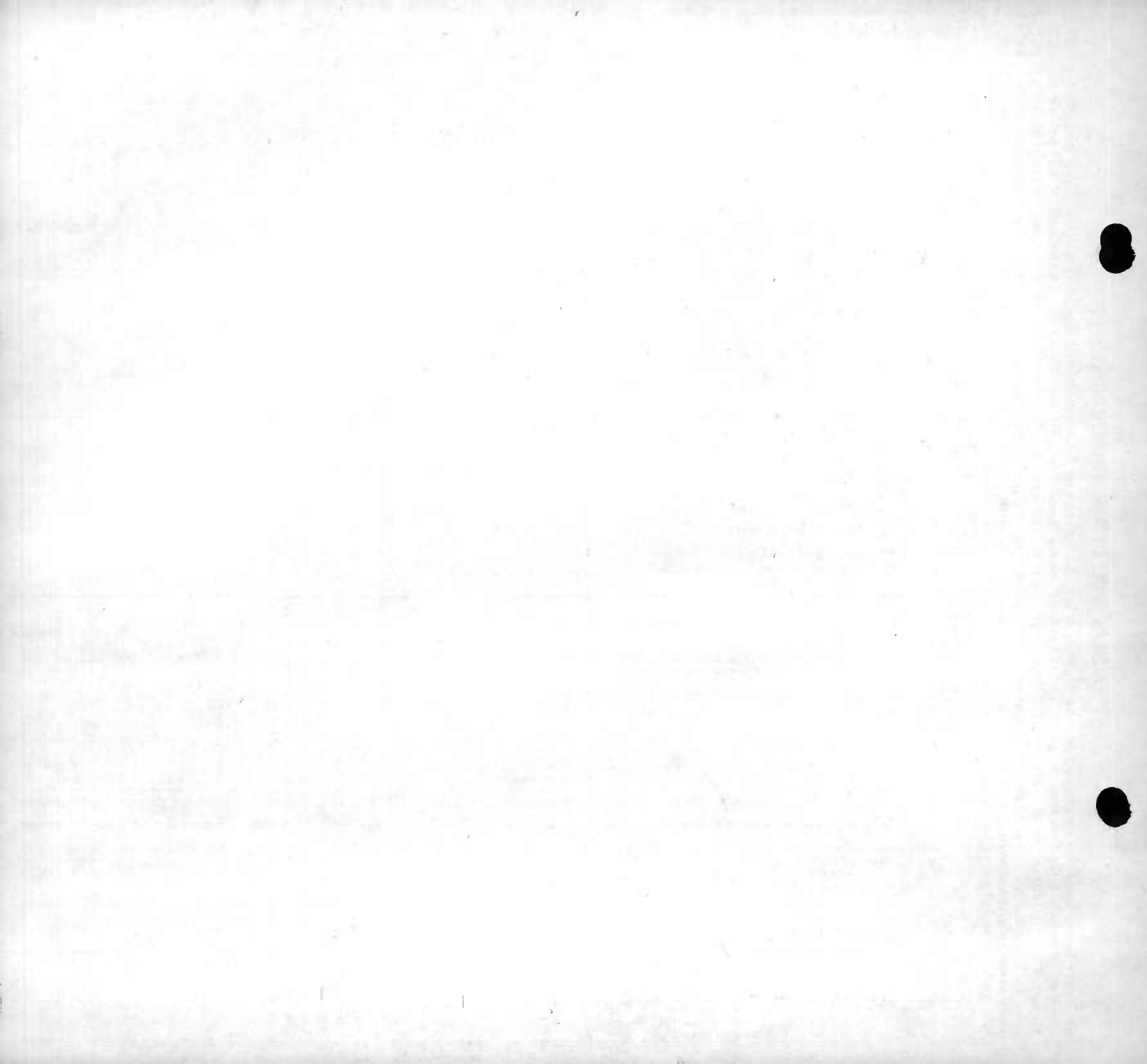
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65-27208 65 6133					65 6133				
CERTIFICATE OF DEATH									
Registered No.									
1. NAME OF DECEASED (Type or Print) DIETZ, Baby Boy					2. DATE AND HOUR OF DEATH 6/9/65 6 ¹⁰ P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 Johns Hopkins Hospital					A. STATE Maryland 27-48				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 12				
					D. STREET ADDRESS (If rural, give location) 6115 Parkway Drive				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Baby		8. DATE OF BIRTH 6/9/65	9. AGE (In years last birthday) 6		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Alba		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Albert J. Dietz Jr.					14. MOTHER'S MAIDEN NAME Janet Bell				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
17. INFORMANT					ADDRESS				
18. 762.57 769.6 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ACIDOSIS DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Infant of Diabetic mother					CAUSE OF DEATH (A) Acidosis DUE TO (B) Asphyxia DUE TO (C) Prematurity? Hyaline Membrane, Shock Infant of Diabetic mother				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) YES					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (1) (this hospital) attended the deceased from 5 PM 6/9 1965 to 6 PM 11/9 1965, that (1) (we) last saw the deceased alive on 6/9 6 PM 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Norman Post					23B. DATE SIGNED 6/9/65				
23C. PHYSICIAN'S NAME (Type) NORMAN POST					23D. ADDRESS Johns Hopkins Hosp.				
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION					24B. DATE 6-10-65				
24C. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS HOSPITAL					24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND				
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1965					25B. NAME OF REGISTRAR Robert E. Finkbeiner				
25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL					ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

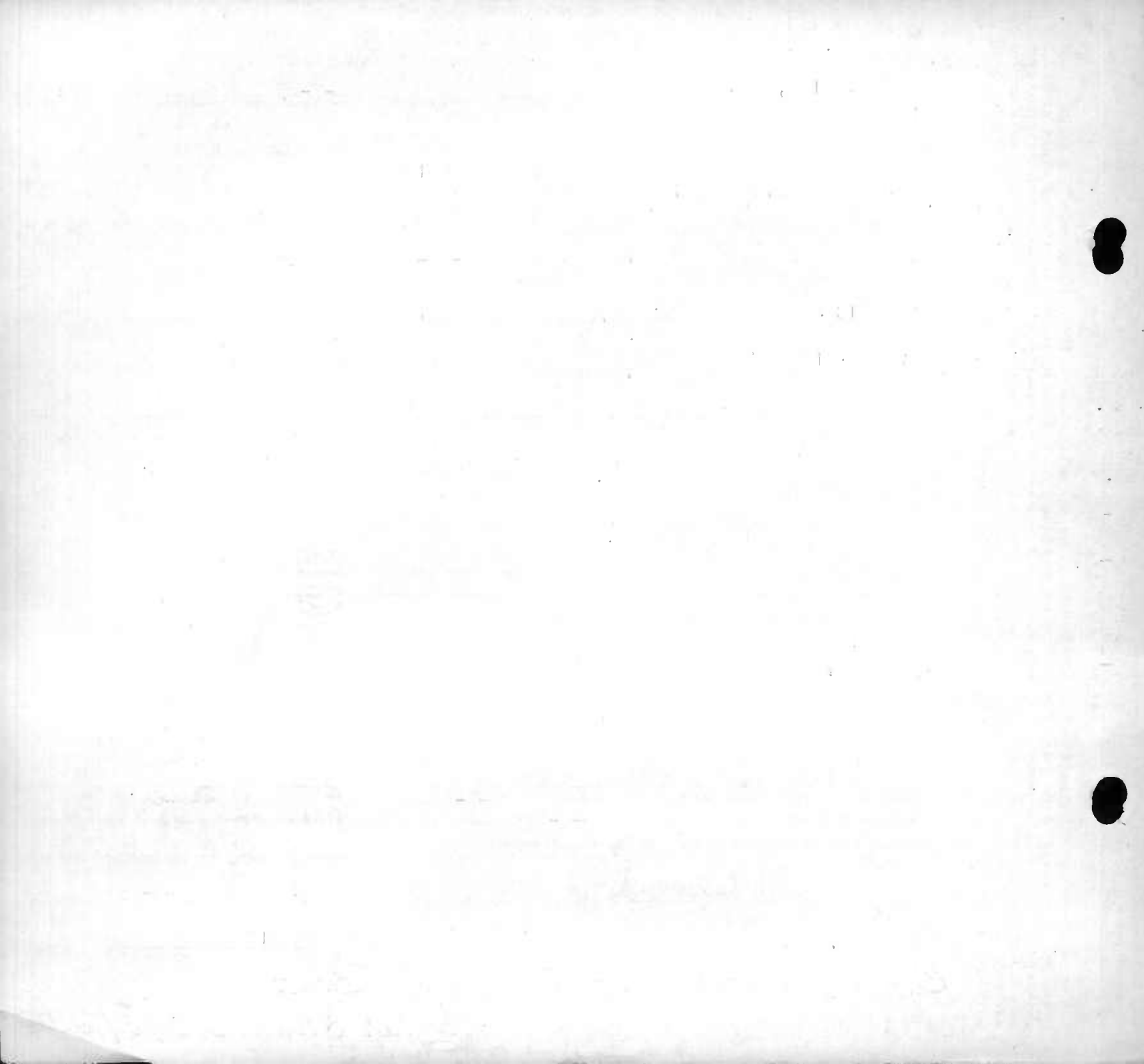
BIRTH NO. <u>Talbot Co., Md. 6134</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 6134</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>FRANCIS KEEN III</u>		2. DATE AND HOUR OF DEATH <u>9 JUN 65</u> <u>2:00 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MARYLAND</u> B. COUNTY <u>CAROLINE</u>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>FEDERALSBURG</u>		D. STREET ADDRESS (If rural, give location) <u>111, BUENA VISTA AVE.</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER M</u>	8. DATE OF BIRTH <u>19 MAY 65</u>	9. AGE (In years last birthday) <u>21</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>U.S.A., MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>FRANCIS KEEN JR.</u>		14. MOTHER'S MAIDEN NAME <u>JULIA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>75451</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <u>CONGENITAL HEART DISEASE</u> DUE TO (B) <u>CHROMOSOME ABNORMALITY</u> DUE TO <u>- TRISOMY 13-15</u> (C) <u>NONE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>NONE</u>					
19A. DATE OF OPERATION <u>2 NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>YES</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>X</u> (this hospital) attended the deceased from <u>28 MAY 1965</u> to <u>9 JUN 1965</u> , that (I) <u>X</u> last saw the deceased alive on <u>9 JUN 1965</u> and that in (my) <u>X</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>X</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>P. O'CRONIN M.B., B.Ch.</u>		23B. DATE SIGNED <u>9 JUN 65</u>		23C. PHYSICIAN'S NAME (Type) <u>P. O'CRONIN</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24B. DATE <u>6-9-65</u>		24C. NAME of CEMETERY or CREMATORY <u>JOHNS HOPKINS HOSPITAL</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 11 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Talbot</u>	
25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>		25D. ADDRESS			



RELEASED SUBJECT TO APPROVAL OF
MEDICAL EXAMINER'S OFFICE
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

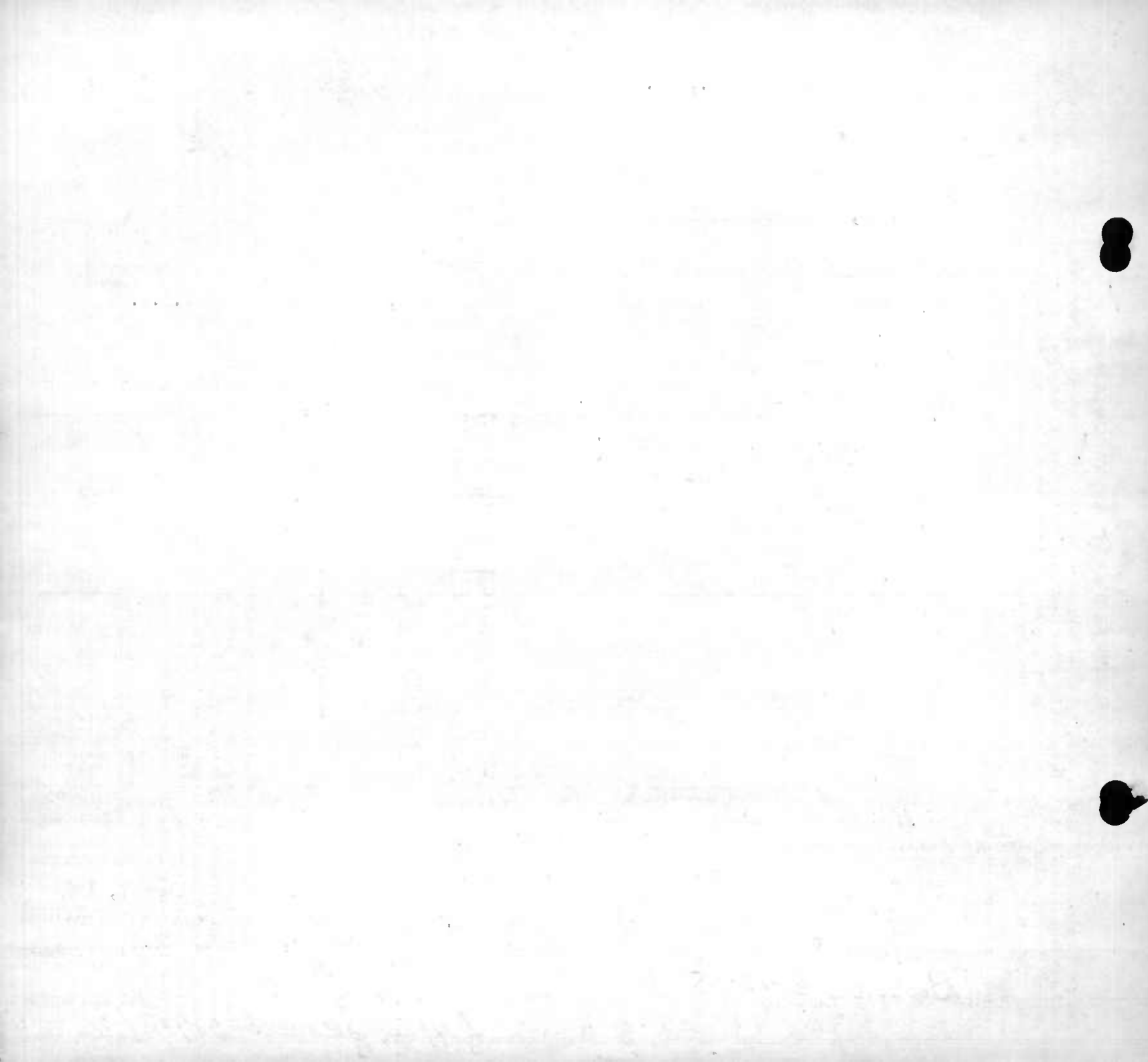
BIRTH NO. 65 6135		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6135	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) GILLIAM, BLANCHE			2. DATE AND HOUR OF DEATH 6-2-65 8:10 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 7-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1732 ASHLAND AVENUE		
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-23-29	9. AGE (In years last birthday) 35	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME JOHN HARRIS		
14. MOTHER'S MAIDEN NAME ESTHER HILL			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT HOSPITAL RECORD		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 581.1 I Pulmonary infarct Ventricular fibrillation 2 ^d to A Acute fatty liver INTERVAL BETWEEN ONSET AND DEATH 11 hours 11 hours			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Chronic alcoholism			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) YES	
21D. TIME OF INJURY (APPROX.) 1 (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-2-65 19 to 6-2-65 19, that (I) (we) last saw the deceased alive on 6-2-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dean H. Lockwood				23B. DATE SIGNED 6-2-65	
23C. PHYSICIAN'S NAME (Type) DEAN H. LOCKWOOD				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-8-65		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION Baltimore		24E. NAME OF REGISTRAR Robert E. Fink		24F. FUNERAL DIRECTOR Rayner Sanders	
25A. DATE REC'D BY HEALTH DEPT. JUN 11 1965		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR 2176 Preston St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

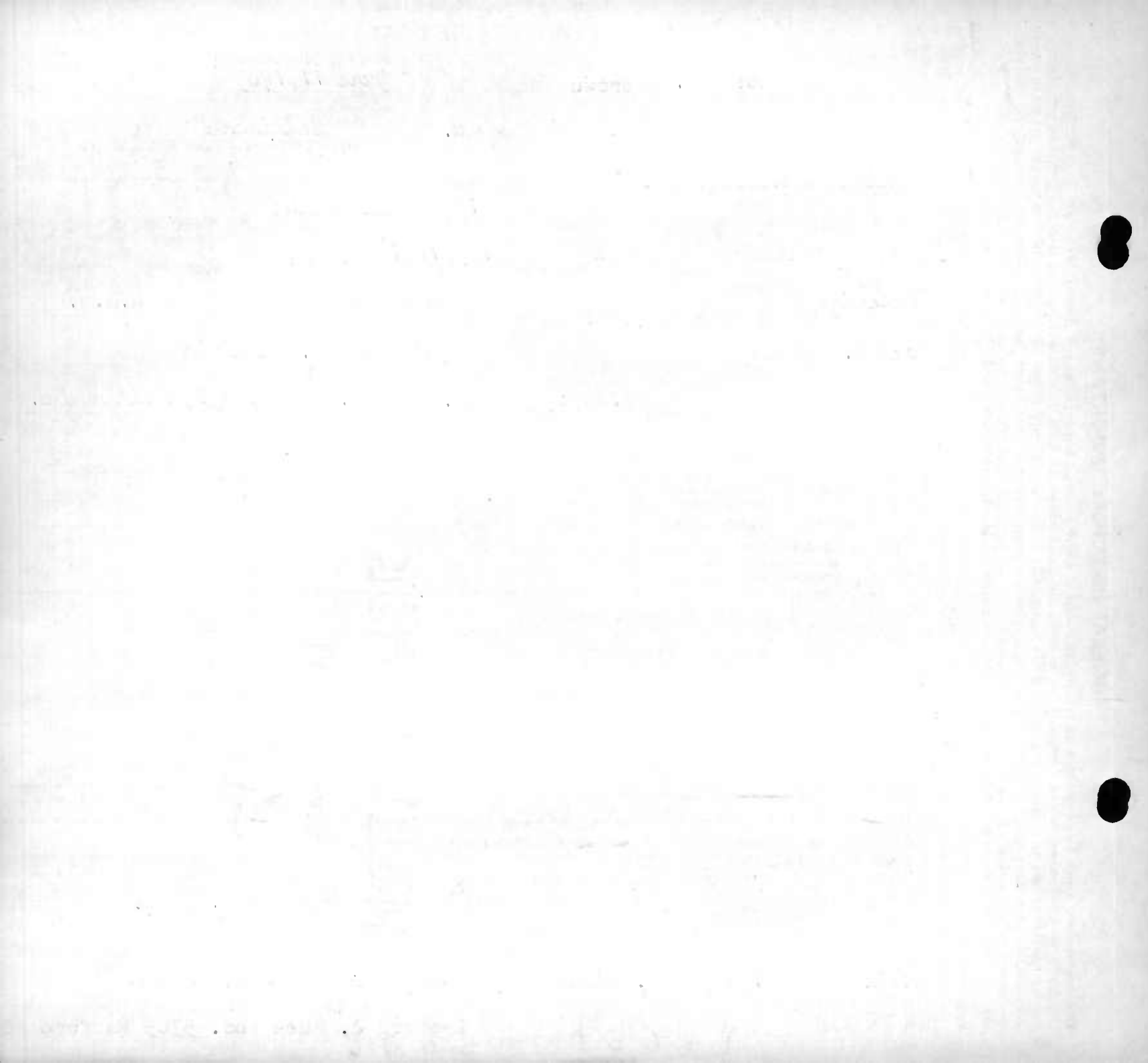
BIRTH NO. 65 6136				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6136	
M.E. CASE NO.				1. NAME OF DECEASED			
(Type or Print)				WILSON, Taylor O., Sr.			
2. DATE AND HOUR OF DEATH				6/7/65 4:05 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Veterans Administration Hospital				Maryland			
3900 Loch Raven Boulevard				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
Baltimore, Maryland 21218				Baltimore			
D. STREET ADDRESS (If rural, give location)				2044 Braddish Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
Male	Negro	Married	12/31/19	45			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Carpenter		Contruction		Baltimore, Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Stetson Wilason				Thelma Hall			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes		8/24/40-6/9/43		220 07 4218		VA Hospital Records 3900 Loch Raven Blvd Baltimore, Maryland 21218	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) Ventricular Fibrillation			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				DUE TO Myocardial Infarction			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 6/7 19 65 to 6/7 19 65, that (I) (we) last saw the deceased alive on 6/7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Mary Lou McIlhane						June 7, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
MARY LOU McILHANEY				VA Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6-10-65		Balt National Em Balt		MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 11 1965		Robert E. Fickel		Rayner Sanders		217 E. Preston St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 6137		CERTIFICATE OF DEATH		Registered No. 65 6137	
1. NAME OF DECEASED (Type or Print) <i>Ann B. Brown</i>				2. DATE AND HOUR OF DEATH <i>June 11, 1965</i> <i>7:15 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>5300</i> D. STREET ADDRESS (If rural, give location) <i>1792 Joan Avenue</i>					
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>1/5/1891</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John J. Burnes</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth C. Sullivan</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>216098967</i>		17. INFORMANT <i>Mr. John B. Brown, 3519 Rolling Rd.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.) <i>578X1</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) <i>Massive Upper 1/2 Hemorrhage</i> DUE TO (B) _____ DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH <i>3 minutes</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<i>Generalized Arteriosclerosis, Severe</i>				<i>5 yrs</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (the hospital) attended the deceased from <i>Oct 1962</i> to <i>June 11 1965</i> . that (I) last saw the deceased alive on <i>27 May 1965</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was did (did not) view the body after death.									
23A. SIGNATURE <i>Joseph F. Li Pira</i> M.D.				23B. DATE SIGNED <i>June 11, 1965</i>					
23C. PHYSICIAN'S NAME (Type) <i>Joseph F. Li Pira</i> M.D.				23D. ADDRESS <i>8400 Loch Raven Blvd. Balt., Md</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/14/65</i>		24C. NAME of CEMETERY or CREMATORY <i>St. Michaels Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Frostburg, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 11 1965</i>				25B. NAME OF REGISTRAR <i>Robert E. Fisher M.A.</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. 5305 Harford Rd</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6138	
BIRTH NO. 65 6138		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Caroline F. Disney</i>		2. DATE AND HOUR OF DEATH <i>June 10, 1965</i> 5:46 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>27-83</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>4810 Gilray Drive</i>		D. STREET ADDRESS (If rural, give location) <i>4810 Gilray Drive</i>			
5. SEX <i>female</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>3-5-1886</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Peter R. Stein</i>		14. MOTHER'S MAIDEN NAME <i>Caroline F. Blomeier</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Peter W. L. Disney</i> ADDRESS <i>same</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>422.1 I Cerebral Thrombosis</i>		CAUSE OF DEATH (A) DUE TO <i>Arteriosclerotic cardiac-vascular Disease</i> (B) DUE TO <i>2 years</i> (C)		INTERVAL BETWEEN ONSET AND DEATH <i>3 mos.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>March 10</i> 19 <i>65</i> to <i>June 10</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>June 10</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>George Sawyer</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6/11/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>GEORGE SAWYER</i>		23D. ADDRESS <i>4808 Harford Rd.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>cremation</i>		24B. DATE <i>6-14-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Greenmount Crematory</i>	
24D. LOCATION <i>Baltimore, Md.</i>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 11 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i> ADDRESS <i>Baltimore, Md.</i>	

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BIRTH NO. 65 6139 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print) JAMES E. JOHNSON 2. DATE AND HOUR PRONOUNCED DEAD
June 9, 1965 1:15 A ^{M.}3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY _____

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

701 E. Chase Street5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) single 8. DATE OF BIRTH 11-1-1923 9. AGE (In years last birthday) 41 If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor 10B. KIND OF BUSINESS OR INDUSTRY single 11. BIRTHPLACE (State or foreign country) Scramville Va 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME

Joseph Johnson

14. MOTHER'S MAIDEN NAME

Willhelmine Poudon15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes, give year or dates of service) yes

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Odoruse Williams - 357 Oak Run18. 420.0 CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) _____
DUE TO

(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)Charles S. Petty, M.D.CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
6/9/6523A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 6-14-1965 23C. NAME OF CEMETERY or CREMATORY Balto Natl Cml 23D. LOCATION (City, town, or county) Balto (State) MD24A. DATE REC'D BY HEALTH DEPT. JUN 11 1965 24B. NAME OF REGISTRAR Robert E. Farley, M.D. 24C. FUNERAL DIRECTOR Choyl W. Wilson ADDRESS Baltimore

VALLEY FORCE

PAGE 101

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6140				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6140	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Wilson Brown, Jr				June 9, 1965 1:15a M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
Provident Hospital		1514 Division Street		Maryland		16-03	
Baltimore, Maryland				C. CITY OR TOWN		(If outside city limits, write RURAL and give township)	
				Baltimore			
D. STREET ADDRESS		(If rural, give location)		949 N. Mount Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Min.
Male	Negro	widowed	Oct. 27, 1881	83	84		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
none				Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
unknown				unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no				Robert Tilghman-son		same	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				(A) ACUTE MYOCARDIAL INFARCTION			
ANTECEDENT CAUSES				(B) CORONARY INSUFFICIENCY			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) ARTERIO SCLEROSIS			
				> AVEU/A			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from June 9, 1965 to June 9, 1965, that (I) (we) last saw the deceased alive on June 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
J. Arroyo				June 9, 1965			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
J. Arroyo		1514 Division Street		Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6-11-1965		Arroyo Cent		Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 11 1965		Robert E. Farley		Choy Wilson		1000 Beantley Ave	

WILLIAM A. W. W. W.

WILLIAM A. W. W. W.

WILLIAM A. W. W. W.

WILLIAM A. W. W. W.

65 6141		BALTIMORE CITY HEALTH DEPARTMENT		65 6141	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
BIRTH NO.					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
LEROY FORTUNE			June 9, 1965 10:00 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 526 N. Chapel St.		
5. SEX male	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH March 26 - 1929	9. AGE (In years last birthday) 35	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Self Employed				Baltimore Md	
13. FATHER'S NAME Clarence Fortune			14. MOTHER'S MAIDEN NAME Lottie Clark		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes			16. SOCIAL SECURITY NO.		
			17. INFORMANT Rube Fortune 119 E. 21st St		
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) Stab wound of the heart		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Street		In front of 1436 E. Monument St.	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
6 9 65 9:20p		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Stabbed during altercation	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
Rudiger Breitenecker				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
Burial		6-14-1965		Baltimore Natl Cem	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
JUN 11 1965		Robert E. Farley, M.D.		Choy C. Wilson, M.D. 100 Cranberry Ave	
				ADDRESS	

VALLEY FORT

MADISON

DEPT

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6142				BALTIMORE CITY HEALTH DEPARTMENT		65 6142	
M.E. CASE NO.				CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) Henry Ebert				2. DATE AND HOUR OF DEATH June 10, 1965 4:15 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 704 Woodbourne Avenue Baltimore, Md. 21212				A. STATE Maryland B. COUNTY 27-48			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 704 Woodbourne Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH April 16, 1869	9. AGE (In years lost birthday) 96	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Piano Technician			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John C. Ebert				14. MOTHER'S MAIDEN NAME Margaret Schell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-32-3000		17. INFORMANT ADDRESS Paul H. Ebert 704 Woodbourne Ave. (Son) Baltimore, Md. 21212		
18. 331 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cerebral Accident Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 1 week							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White <input type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 5 19 65 to June 10 19 65 , that (I) (we) last saw the deceased alive on June 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22A. SIGNATURE Laurence C. Post						22B. DATE SIGNED 6/11/65	
23C. PHYSICIAN'S NAME (Type) Dr. Laurence Post				23D. ADDRESS M.D. 6805 York Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 6/14/65		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR ADDRESS Eugenia K. Seitz 5209 York Road Seitz Funeral Home Baltimore, Md.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 6143		65 6143		65 6143	
<div> <div>M.E. CASE NO.</div> <div>1. NAME OF DECEASED</div> <div>(Type or Print) EMMA MARY JOHNSON (Knox)</div> </div> <div> <div>2. DATE AND HOUR OF DEATH</div> <div>6-12-65 8⁴⁵ A.M.</div> </div>					
<div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div> <div>FULL NAME OF HOSPITAL OR INSTITUTION</div> <div>(If not in hospital or institution, give street address or location)</div> <div>UNION MEMORIAL HOSPITAL</div> </div>			<div>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</div> <div> <div>A. STATE</div> <div>B. COUNTY</div> <div>MARYLAND</div> </div> <div> <div>C. CITY OR TOWN</div> <div>(If outside city limits, write RURAL and give township)</div> <div>BALTIMORE</div> </div> <div> <div>D. STREET ADDRESS</div> <div>(If rural, give location)</div> <div>1005 PROVIDENCE Str.</div> </div>		
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 5/28/04	9. AGE (In years last birthday) 61	<div>If Under 1 Yr. Months Days</div> <div>If Under 24 Hrs. Hours Min.</div>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10B. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Keeney		14. MOTHER'S MAIDEN NAME Addie Johnson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-30-5508		17. INFORMANT CHART- UNION Memorial Hospital	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 170X I		CAUSE OF DEATH (A) DUE TO Acute Cor Pulmonale		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Metastatic lung cancer		± 1 month	
(C) DUE TO Probable cancer of breast				± 1 year	
<div>II</div> <div>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</div>					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (the) (this hospital) attended the deceased from 6/11 19 65 to 6/12 19 65 , that (he) (we) last saw the deceased alive on 6/12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lawrence J. Lieberman				23B. DATE SIGNED 6/12/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/16/65		24C. NAME OF CEMETERY or CREMATORY Pleasant Rest	
24D. LOCATION (City, town, or county) (State) Towson, Balto. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965			
25B. NAME OF REGISTRAR Robert E. Parker		25C. FUNERAL DIRECTOR Donal. Lieberman			
25D. ADDRESS 1701 Mt. Celloh St. Balto. Md.					

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1

65 6144

BALTIMORE CITY HEALTH DEPARTMENT

65 6144

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) THOMAS THOMPSON

2. DATE AND HOUR PRONOUNCED DEAD 6/10/65 12:45 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 621 S. Charles St.

5. SEX male

6. RACE colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M

8. DATE OF BIRTH 8-22-1904

9. AGE (In years last birthday) 60

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

11. BIRTHPLACE (State or foreign country) N. Chester S.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Samuel Thompson

14. MOTHER'S MAIDEN NAME Rachel Alexander

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Edith Thompson - Furance Branch Rd

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

ASSOCIATE MEDICAL EXAMINER

DATE SIGNED 6/11/65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE 6-15-65

23C. NAME OF CEMETERY or CREMATORY Mount Auburn Ct

23D. LOCATION (City, town, or county) Baltimore City

24A. DATE REC'D BY HEALTH DEPT. JUN 14 1965

24B. NAME OF REGISTRAR Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

24D. ADDRESS

VS 151-REV. 1/1/65

VALLEY PEOPLE

AGRICULTURE

James H. [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6145		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6145	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ALICE BRENNER JACQUES		2. DATE AND HOUR OF DEATH JUNE 9, 1965 11 a M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-48		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 12	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 711 Highland Drive.		D. STREET ADDRESS (If rural, give location) 711 HIGHLAND DRIVE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH FEB. 24, 75	9. AGE (In years lost birthday) 92	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SMITHSBURG Md	
13. FATHER'S NAME LUCIEN BRENNER		14. MOTHER'S MAIDEN NAME CATHERINE FIERY		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS ARTHUR B. JACQUES - SAME	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Coronary Sclerosis (B) DUE TO Generalized Arterio Sclerosis (C) DUE TO Senility		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1965 19 to June 5 1965 that (I) (we) last saw the deceased alive on June 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Paul Byerly		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/9/65	
23C. PHYSICIAN'S NAME (Type) M. Paul Byerly		23D. ADDRESS 5820 York Road Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-12-65		24C. NAME OF CEMETERY or CREMATORY Smithsburg Cemetery	
24D. LOCATION Smithsburg, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Scott F. Minnich & Son Hag. Md.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6146				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6146	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Mrs. Margaret S. Talbott		June 9, 1965 11 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
801 West 35th Street				Maryland 13-08			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				801 West 35th Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.		
Female	White	Married	Dec. 17, 1892	72			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
At Home				Washington, D. C.		U S A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Thomas A. Buell				Martha W. Parker			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		215-22-2740		Earl L. Talbott 801 West 35th Street			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) Uremia - Nephrosclerosis 1 mo. 10 years			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(B) Diabetes mellitus. 25 years			
ANTECEDENT CAUSES				(C) Myocardial infarction. 3 weeks - 10 years			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from March 22 1965 to June 9 1965, that (I) (we) last saw the deceased alive on June 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Anacleto Fernandez Brito M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				June 10-65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
ANACLETO. C. FERNANDEZ-BRITO M.D.				824 W 36th St. Baltimore, Md 21211			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		June 12, 1965		Weisburg		Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 14 1965		Robert E. Talbott		Burgee Funeral Home		3631 Falls Road	

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BIRTH NO. 65 6147 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 6147

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Edward Lacie Ellerbe

2. DATE AND HOUR PRONOUNCED DEAD

June 13, 1965 2:50 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3134 Gwynn Falls Parkway

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

8-6-1906

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Auto Mechanic Helper Auto Agency

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Rockingham N.C.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Hoyes Ellerbe

14. MOTHER'S MAIDEN NAME

Willie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

212-05-3288

17. INFORMANT

ADDRESS

GEOFF ELLERBE 3134 Gwynn Falls Pkwy

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Hypertensive Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 13, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-16-65

23C. NAME of CEMETERY or CREMATORY

Mt Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

JUN 14 1965

24B. NAME OF REGISTRAR

Robert E. Farkley, M.D.

24C. FUNERAL DIRECTOR

Marshall P. Hayes 638 N. Gilmor St

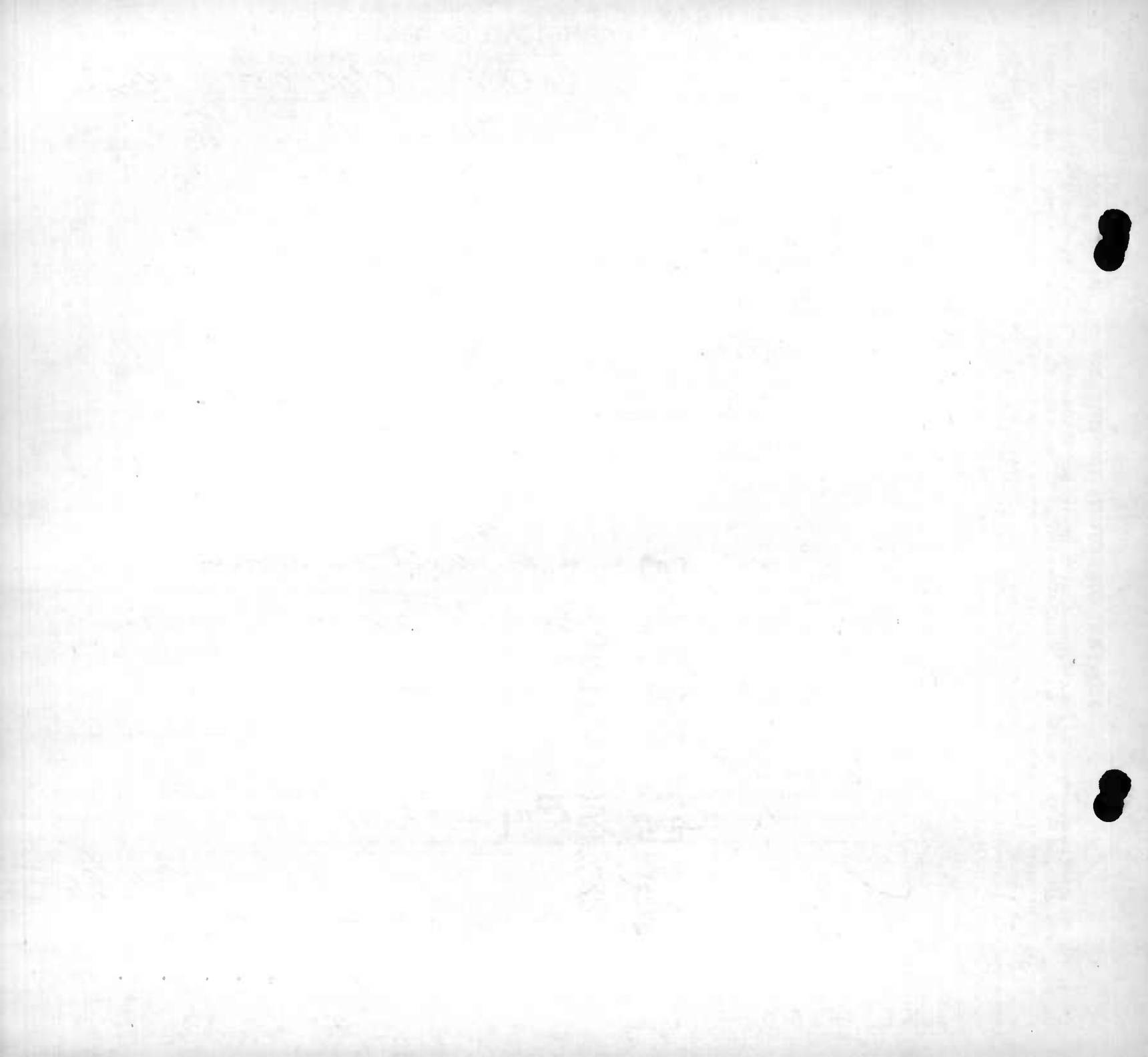
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										65 6148		
BIRTH NO.										Registered No.		
M.E. CASE NO.												
1. NAME OF DECEASED (Type or Print) <i>Buehler, Edna Cath.</i>					2. DATE AND HOUR OF DEATH <i>6/11/65 4:45 PM</i>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION <i>North Charles Gen. Hosp.</i>					A. STATE <i>Md.</i>							
(If not in hospital or institution, give street address or location)					B. COUNTY <i>City</i>							
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>							
					D. STREET ADDRESS (If rural, give location) <i>110 E. Clement St.</i>							
5. SEX <i>Female</i>		6. RACE <i>W Amer</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>7-12-03</i>		9. AGE (In years lost birthday) <i>61</i>		If Under 1 Yr. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>Md.</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					13. FATHER'S NAME <i>Frank Mental</i>					14. MOTHER'S MAIDEN NAME <i>Mary Peters</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hospital Record.</i>					
18. <i>331X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH (A) <i>Cerebral Hemorrhage</i> DUE TO					INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <i>Hypertension</i> DUE TO					<i>many yrs</i>		
					(C) <i>Arteriosclerosis</i>					<i>" "</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					<i>Head Trauma</i>					<i>10 days</i>		
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <i>6-1-65</i>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <i>6-1-1965</i> to <i>6-11-1965</i> , that (I) (we) lost saw the deceased alive on <i>6-11-1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.												
23A. SIGNATURE <i>[Signature]</i>								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6/11/65</i>		
23C. PHYSICIAN'S NAME (Type) <i>Dr. W. Hohn</i>								23D. ADDRESS <i>102 E. Fort Ave.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE <i>6 15 65</i>			24C. NAME of CEMETERY or CREMATORY <i>Cedar Hill</i>			24D. LOCATION (City, town, or county) (State) <i>Brooklyn, A. A. Co. Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 14 1965</i>			25B. NAME OF REGISTRAR <i>Edna E. Fairbank</i>			25C. FUNERAL DIRECTOR <i>Mc Gully</i>			ADDRESS <i>130 E. Fort Ave</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6149	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CORBIN, MRS CATHERINE M.				2. DATE AND HOUR OF DEATH 6-10-1965		10-15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home and Hospital Baltimore 31, Md.				A. STATE B. COUNTY Maryland, 21157 Carroll			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Westminster 36-27			
				D. STREET ADDRESS (If rural, give location) 30 West Green Street			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-5-1898	9. AGE (In years last birthday) 66 yrs	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholas, Lingg				14. MOTHER'S MAIDEN NAME Appolonia, Lawrence			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -				16. SOCIAL SECURITY NO. 215-42-7051		17. INFORMANT ADDRESS Mr. John E. Corbin 30 W. Green St. Westminster, Md.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute pulmonary edema - few hours				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute myocardial infarction - 10 days.				(A) DUE TO		(B) DUE TO	
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 6-1-1965 to 6-10-1965 , that (I) (we) last saw the deceased alive on 6-10-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Kishor. C. Mehta				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-10-65	
23C. PHYSICIAN'S NAME (Type) KISHOR C. MEHTA				23D. ADDRESS Church Home and Hospital, Balt. 31 Maryland			
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE 6/14/65		24C. NAME of CEMETERY or CREMATORY Meadow Branch Cemetery		24D. LOCATION (City, town, or county) (State) nr Westminster, Carroll, Maryl-	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR J. S. Myers Jr.		ADDRESS and Westminster, Md.	

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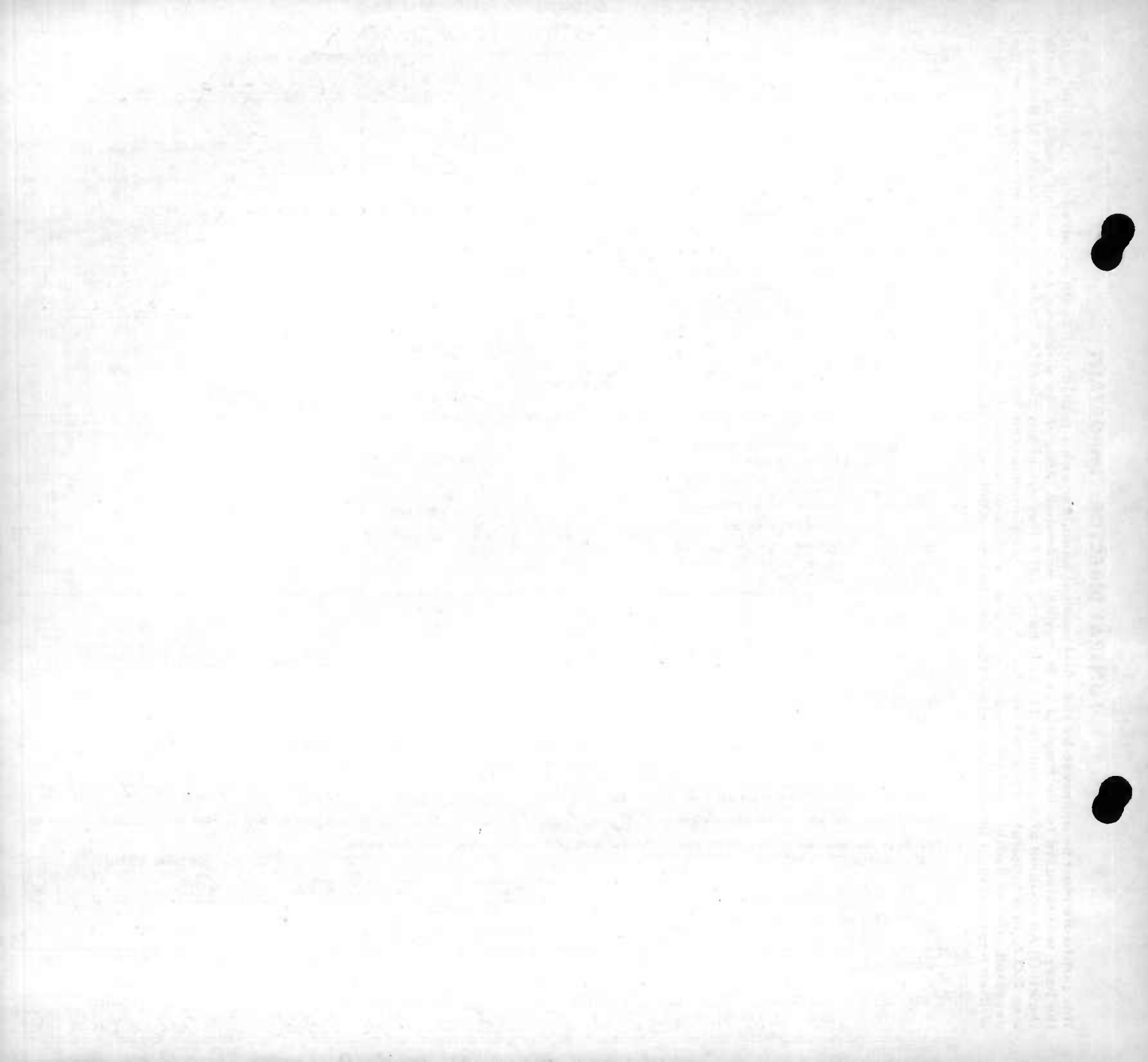
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		BIRTH NO. 65 6150		CERTIFICATE OF DEATH		Registered No. 65 6150	
1. NAME OF DECEASED (Type or Print) <i>Schaub, Helen E.</i>				2. DATE AND HOUR OF DEATH <i>6-11-65 9:25 AM</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Bon Secours Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Baltimore</i> B. COUNTY <i>28 Balto</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>CATONSVILLE 5300</i> D. STREET ADDRESS (If rural, give location) <i>1920 TADCASTER RD</i>			
5. SEX <i>Female</i>	6. RACE <i>W</i>	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>		8. DATE OF BIRTH <i>3/2/19</i>	9. AGE (In years last birthday) <i>46</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Driver, Albert</i>				14. MOTHER'S MAIDEN NAME <i>ALICE HILTON</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>HOSPITAL RECORDS</i>		ADDRESS	
18. <i>5810 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO <i>Aspirated Pneumonia</i> (B) DUE TO <i>Carcinoma of Liver</i> (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>June 9 1965</i> to <i>June 11 1965</i> , that (I) (we) last saw the deceased alive on <i>June 11 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Zenaida C. Palad</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>June 11, 1965</i>			
23C. PHYSICIAN'S NAME (Type) <i>ZENALDA C. PALAD</i>		23D. ADDRESS <i>BON SECOURS HOSP. BALTO. 23 MD</i>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>6/14/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>MEADOWRIDGE</i>		24D. LOCATION (City, town, or county) (State) <i>HOWARD CO. MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 14 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>E. S. MACNABB</i>		ADDRESS <i>301 FREDERICK RD</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 6151	
BIRTH NO. 65 6151		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARKS, James A.		2. DATE AND HOUR OF DEATH 6/10/65 4:30 A	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pennsylvania B. COUNTY K-33 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Conshohocken D. STREET ADDRESS (If rural, give location) 121 West Tenth Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/17/18	9. AGE (In years lost birthday) 47	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Conshohocken, Pa.		12. CITIZEN OF WHAT COUNTRY? U.A.S.	
13. FATHER'S NAME Edward Marks				14. MOTHER'S MAIDEN NAME Mary McEvoy			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5/14/46 To 9/15/47		16. SOCIAL SECURITY NO. 717 09 0240		17. ADDRESS V.A. Hospital Baltimore, Md. 21218			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cor Pulmonale due to pulmonary arterial hypertension				CAUSE OF DEATH (A) DUE TO Obstructive Emphysema (B) DUE TO Tuberculosis, pulmonary, far advanced active (C) DUE TO Laennac's cirrhosis		INTERVAL BETWEEN ONSET AND DEATH 4 years 5 years 14 years	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from November 1st 19 61 to June 10th 19 65 , that (1) (we) last saw the deceased alive on June 10th 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Ralph H. Twining</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/10/65	
23C. PHYSICIAN'S NAME (Type) RALPH H. TWINING				23D. ADDRESS Veterans Administration Hospital Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE June 11, 65		24C. NAME OF CEMETERY or CREMATORY St. Benedict's Cem.		24D. LOCATION (City, town, or county) (State) Conshohocken, Montgomery Co. Pa.	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR <i>Ralph E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS Wm Cook-Brooks, Inc. 1217 St. Paul St.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

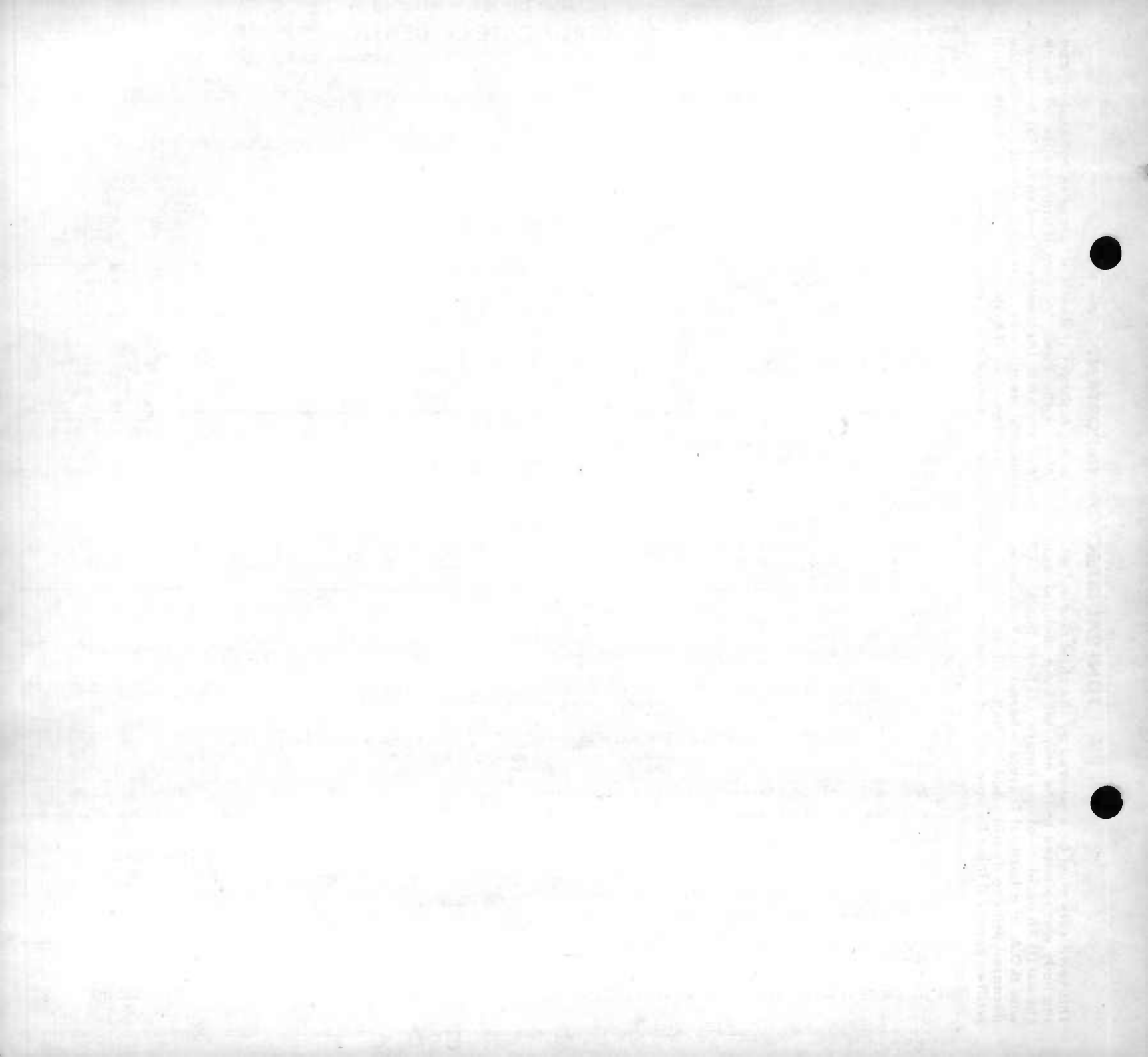
BALTIMORE CITY DEPARTMENT				BIRTH NO. 65 6152		REGISTERED NO. 65 6152	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				MARGARET FOWBLE		6-7-65 10:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Maryland Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
MERCY HOSPITAL				Lutherville		53-00	
D. STREET ADDRESS (If rural, give location)				1508 Riderwood Avenue			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Female		White		Married		Dec. 24, 1908	
9. AGE (In years last birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
36		Registrar		Nursing Home		Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
USA		Michael B. Barrett		Margaret Leonard		No None	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH	
217-01-5909		Joshua Fowble, 1508 Riderwood Ave. Lutherville		1508 Riderwood Ave. Lutherville		INTERVAL BETWEEN ONSET AND DEATH	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		20. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		22. I certify that (I) (this hospital) attended the deceased from 6-6-1965 to June 7, 1965, that (I) (we) last saw the deceased alive on 10:15 June 7, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
443X I		Cerebrovascular Accident (massive - hemorrhagic)		28 hours		12 yrs.	
HPN		ASCD					
MEDICAL CERTIFICATION		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED		June 8, 1965	
Carmelita A. Cendano		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Jun. 11, 1965		Dulaney Valley Memorial Cem.		Cockeysville, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 14 1965		Robert E. Johnson		John Burns Sons, Towson, Maryland			

4323-10-712

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 6153					Registered No. 65 6153				
BIRTH NO.					BALTIMORE CITY HEALTH DEPARTMENT				
M.E. CASE NO.					BALTIMORE CITY HEALTH DEPARTMENT				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
HAZEL GENEVE A POWER					10 June 1965 4:00 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
Bon Secours Hospital					Maryland Baltimore				
5. SEX					6. DATE OF BIRTH				
Fe W					3-20-21				
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)					9. AGE (In years last birthday)				
Widowed					44				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					11. BIRTHPLACE (State or foreign country)				
Waitress					Minnesota				
10B. KIND OF BUSINESS OR INDUSTRY					12. CITIZEN OF WHAT COUNTRY?				
Restaurant					USA.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Thims, Carl					Hilda CARLSON				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give War or dates of service)					16. SOCIAL SECURITY NO.				
No					475-16-5834				
17. INFORMANT					ADDRESS				
Walter C. Buechi					8525 Philadelphia Rd.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					acute pulm. edema St. Loke				
19. DATE OF OPERATION					20A. AUTOPSY? (Yes or No)				
16-8-65					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
Ventral Hernia					21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21E. INJURY OCCURRED				
21D. TIME OF INJURY (APPROX.)					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 10 June 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					23A. SIGNATURE				
23B. DATE SIGNED					23C. PHYSICIAN'S NAME (Type)				
6-10-65					Tre-Wu Tai				
23D. ADDRESS					24A. BURIAL CREMATION, REMOVAL (Specify)				
Bon Secours Hospital					Burial				
24B. DATE					24C. NAME OF CEMETERY or CREMATORY				
6-14-65					Baltimore Cemetery				
24D. LOCATION (City, town, or county) (State)					25A. DATE REC'D BY HEALTH DEPT.				
Baltimore, Maryland					JUN 14 1965				
25B. NAME OF REGISTRAR					25C. FUNERAL DIRECTOR				
Philip E. Coach					1211 Chesaco Ave.				



FUNERAL DIRECTOR: IMPORTANT

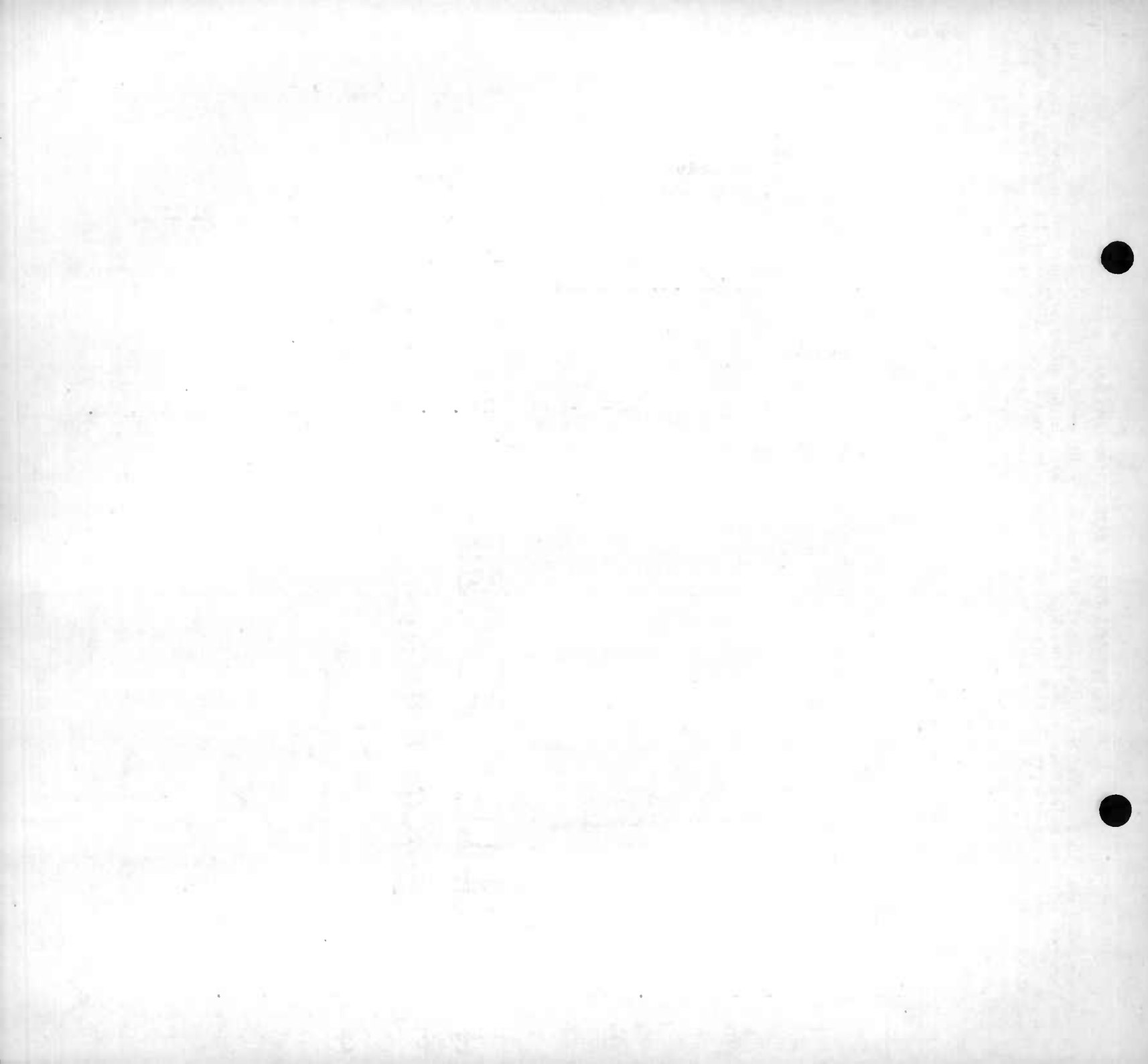
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 665 56154	
BIRTH NO. 665 56154		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charles E. Williams (Williams)		2. DATE AND HOUR OF DEATH 6/9/65 3:07 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Harford C. CITY OR TOWN (If outside city limits, write RURAL and give township) Magnolia 62-00 D. STREET ADDRESS (If rural, give location)			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11/9/23	9. AGE (In years last birthday) 41	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filling Station Attendant		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Isaac Williams		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-22-3952		17. INFORMANT Margaret D. Williams, Magnolia, Md.	
18. 463X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cellulitis, RT leg + Thrombophlebitis		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cor pulmonale, Restrictive Chest Disease					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/11/65 to 6/9/65 that (I) (we) last saw the deceased alive on 6/9/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Jonathan Tuerk		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/9/65	
23C. PHYSICIAN'S NAME (Type) Jonathan Tuerk		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 13, 1965		24C. NAME of CEMETERY or CREMATORY John Wesley Cemetery	
24D. LOCATION (City, town, or county) (State) Magnolia Harford Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Salisbury		25C. FUNERAL DIRECTOR ADDRESS Howard K. McComas & Son, Abingdon, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

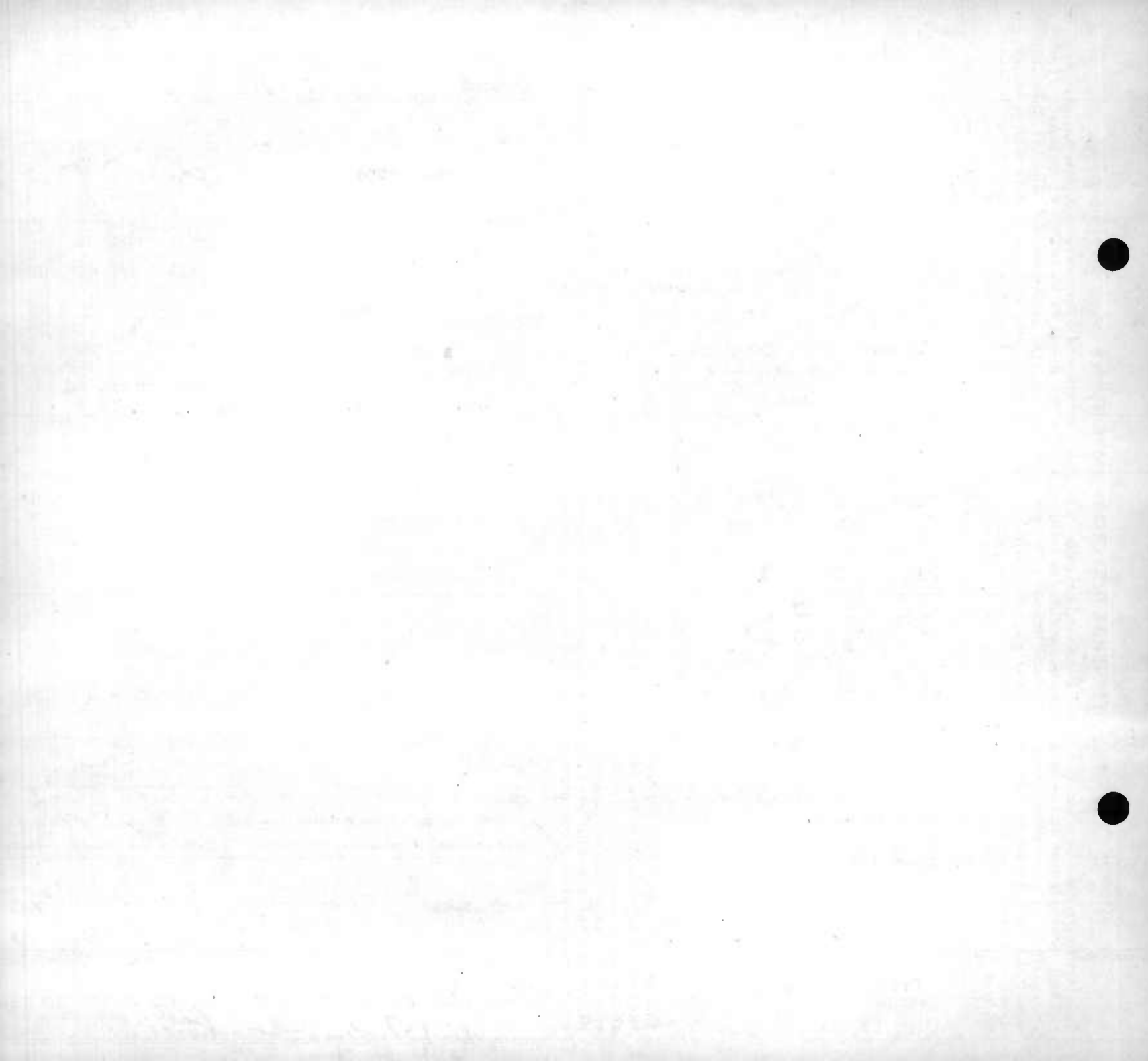
BIRTH NO. 65 6155				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6155	
1. NAME OF DECEASED (Type or Print) Alice Holsey				2. DATE AND HOUR OF DEATH June 8, 1965 8:00 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 27-38			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1424 Meridene Drive Baltimore, Maryland 21212				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1424 Meridene Drive 21212			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 12/30/1902	9. AGE (In years lost birthday) 62	10. CITIZEN OF WHAT COUNTRY? If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James McKeldin				14. MOTHER'S MAIDEN NAME Dora Grief			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 212-05-8102		17. INFORMANT Rev. J. Raymond Holsey		ADDRESS 101 W. Market St. Snow Hill, Md.	
18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Respiratory Failure (B) DUE TO Hemiplegia (C) Hypertension + arteriosclerotic Cardiovascular disease			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1945 to June 8 1965 that (I) (we) last saw the deceased alive on June 5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE I. S. Borofsky				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/9/65	
23C. PHYSICIAN'S NAME (Type) I. S. BOROFSKY				23D. ADDRESS 600 N. Howard St. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/10/1965		24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR John J. Fisher & Sons		ADDRESS Baltimore, Md. 21217	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

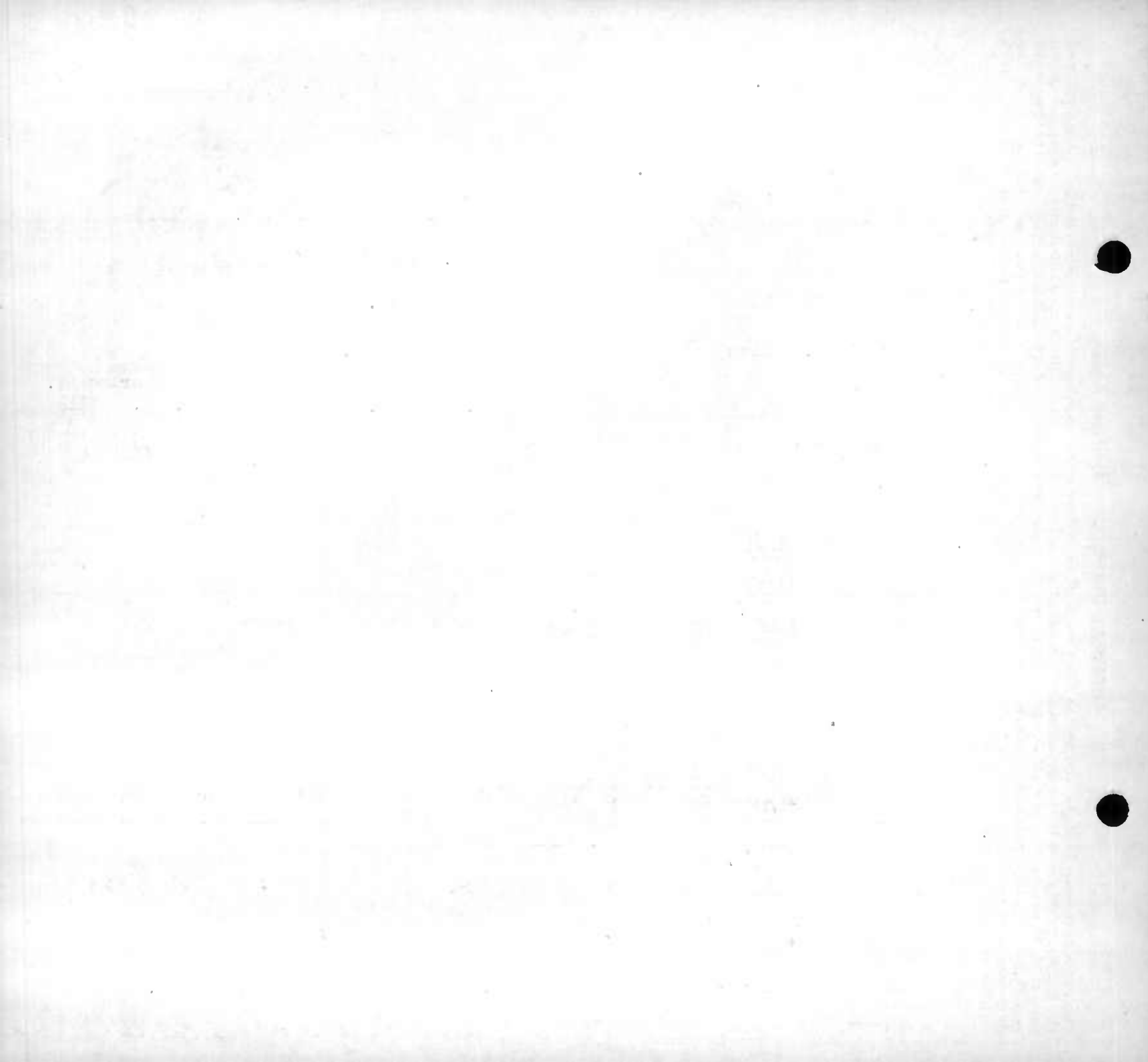
BIRTH NO. 65 6156		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6156	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Carmichael, Edward Raymond		2. DATE AND HOUR OF DEATH 6-11/1965 8 25 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Bon Secours Hospital		A. STATE B. COUNTY Baltimore Md.			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 28-04			
		D. STREET ADDRESS (If rural, give location) 522 Old Orchard Rd 29			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Oct. 13, 1880	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10B. KIND OF BUSINESS OR INDUSTRY Wholesale Bakers Supplies		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Thomas Eugene Carmichael		14. MOTHER'S MAIDEN NAME Margaret Smith		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Samuel H. Bryant Balto., Md. 29	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 + 260X		CAUSE OF DEATH (A) DUE TO Acute coronary thrombosis (B) DUE TO Generalized arteriosclerosis (C) _____		INTERVAL BETWEEN ONSET AND DEATH 1 hr years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes Mellitus		years	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) no	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 11 1965 to June 11 1965, that (I) (we) last saw the deceased alive on June 11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gerardo C. Palad		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 11, 1965	
23C. PHYSICIAN'S NAME (Type) GERARDO C. PALAD		23D. ADDRESS Bon Secours Hosp. 700 Pulaski St. Balto 23			
24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24B. DATE 6/15/1965	24C. NAME of CEMETERY or CREMATORY Loudon Park Crematory		24D. LOCATION (City, town, or county) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Wm. J. Tishman & Sons	
				ADDRESS Balto., Md. 21217	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6157				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6157	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) Margie J. Mears				2. DATE AND HOUR OF DEATH June 8, 1965 7 45 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
3401 North Charles St.		Baltimore, Maryland 21218		Maryland		12-02	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)			
Baltimore				3401 North Charles St. 21218			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Female	White	Widowed	Sept. 8, 1872	92	Housewife	Va.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Benjamin J. Kellam				Catherine A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				None		Mr. Elton Y. Mears	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443X1				Cerebral vascular hemorrhage		4 wks	
ANTECEDENT CAUSES				HASCD			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				HA SCVD			
II				Aspiration pneumonia		4 wks	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
<input type="checkbox"/>							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 10-27 19 64 to 6-8 19 65 , that (I) (we) last saw the deceased alive on 6-8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Alfred Y. Ossman Jr.						6-9-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/11/1965		Meadowridge Mem. Cemetery		Elkridge, Howard Co.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 14 1965		Robert E. Fairbank		Wm. J. Fickens & Sons		Baltimore, Md. 17	



1

W-345

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 6158 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 6158

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Elizabeth Woodland

2. DATE AND HOUR PRONOUNCED DEAD June 12, 1965 11:07 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1623 Hakesley Place

5. SEX Female

6. RACE Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed

8. DATE OF BIRTH Feb 28, 22

9. AGE (in years last birthday) 42

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James A. Chase

14. MOTHER'S MAIDEN NAME Mary A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS William Woodland 1623 Hakesley Pl.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH

MASSIVE SUBARACHNOID HEMORRHAGE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED June 13, 1965

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE 6-16-65

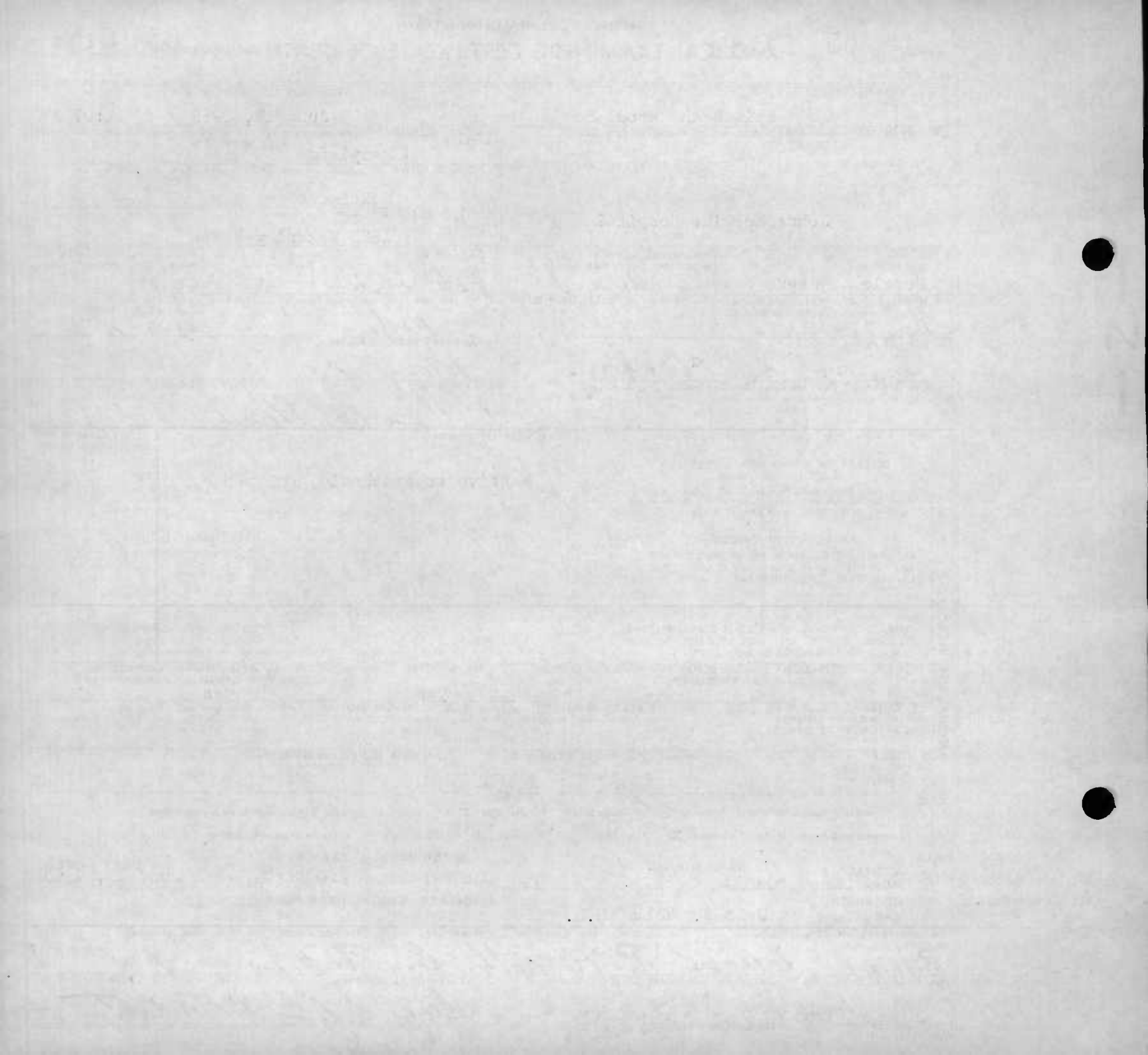
23C. NAME OF CEMETERY or CREMATORY Balt. Ho. Neth. Cem.

23D. LOCATION (City, town, or county) (State) Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT. JUN 14 1965

24B. NAME OF REGISTRAR Robert E. Finkbeiner

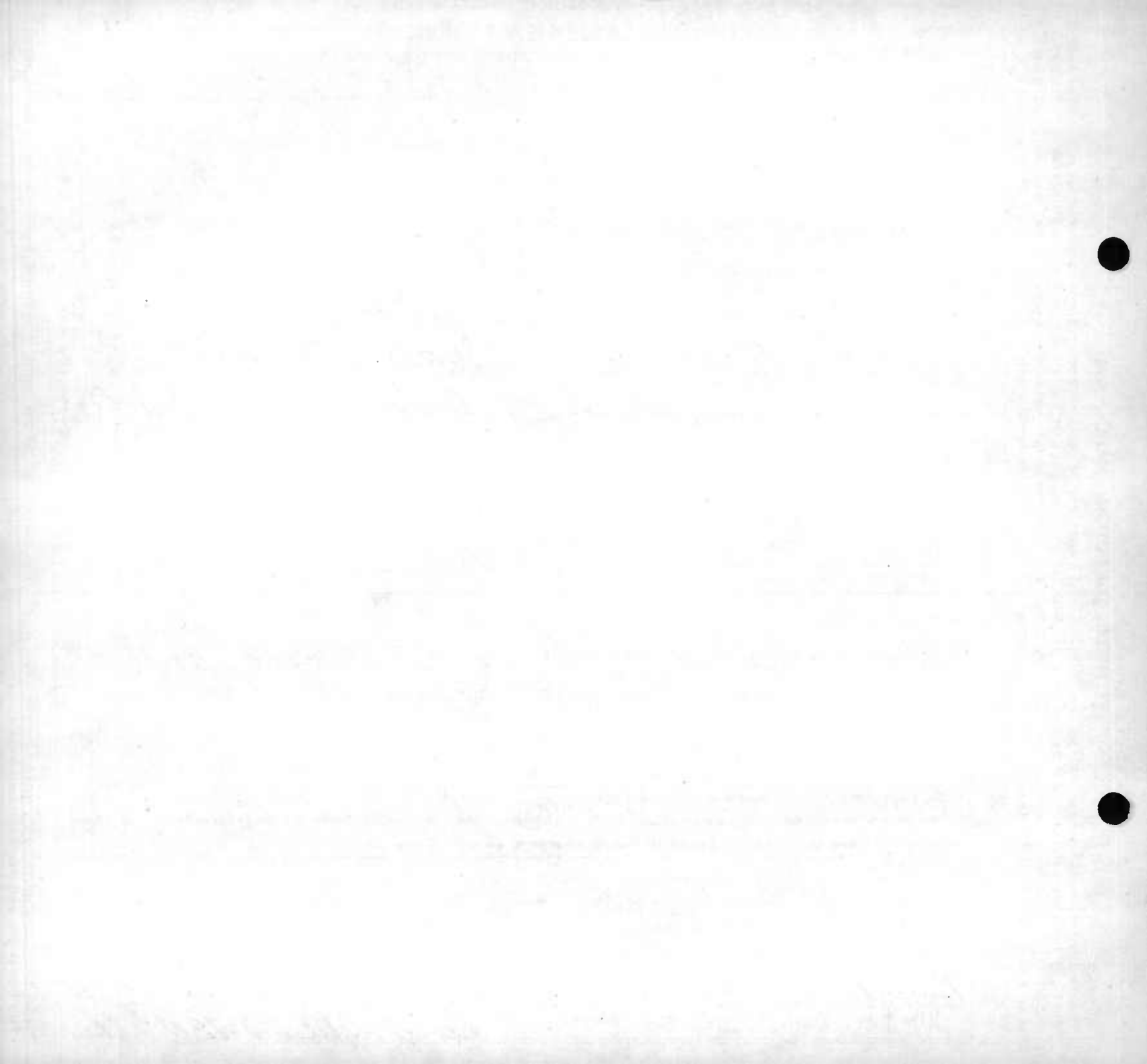
24C. FUNERAL DIRECTOR ADDRESS George H. Lila 1346 N. Calhoun St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

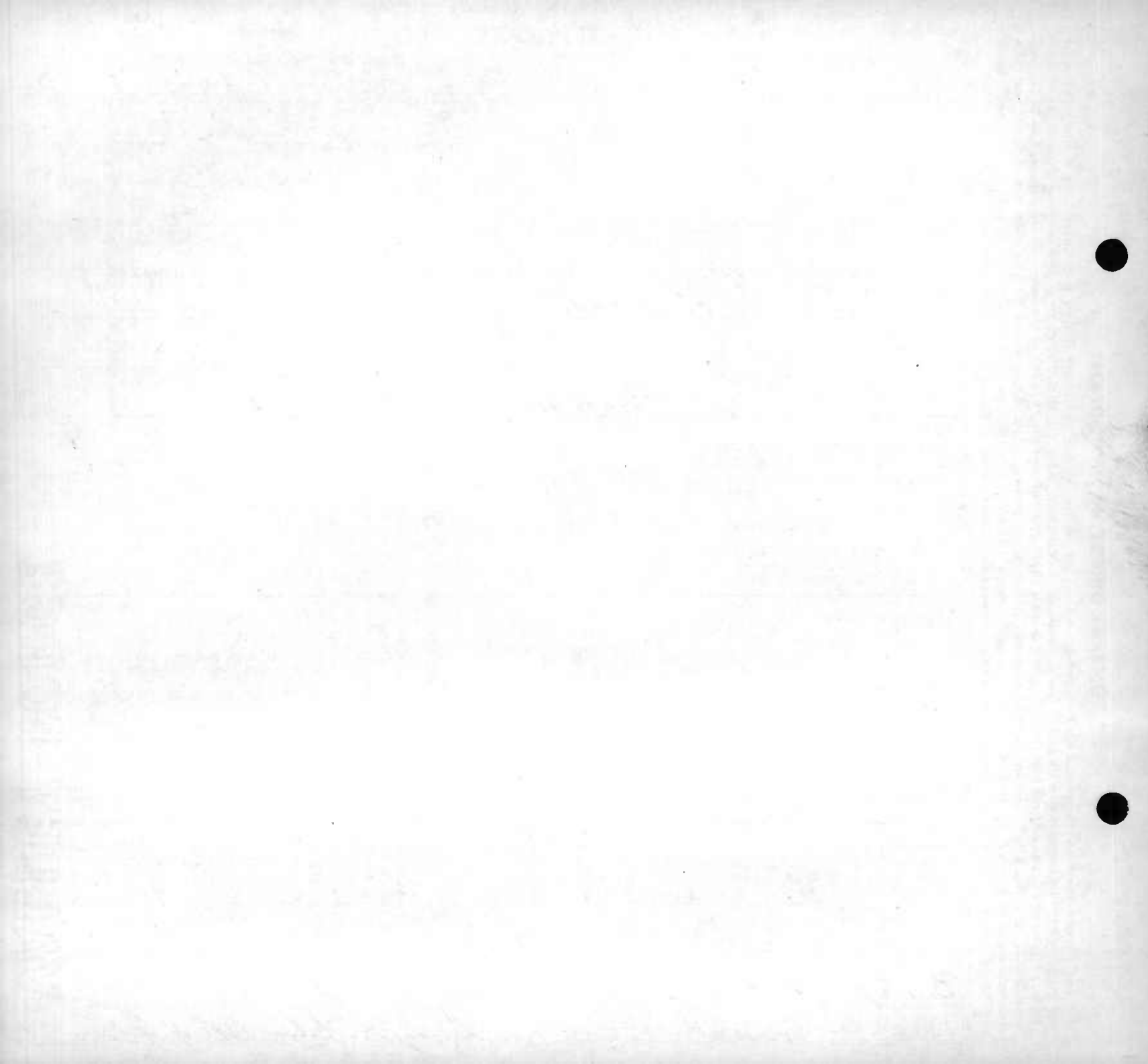
BIRTH NO. 65 6159		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6159	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		RANPOLDPH HOLLAND		10 June 1965 12 noon M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
UNIVERSITY HOSP. BALTIMORE MD.				MARYLAND ANNIS Arundel	
5. SEX M 6. RACE IV 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				D. STREET ADDRESS (If rural, give location)	
10B. KIND OF BUSINESS OR INDUSTRY				GLEN BURVIE 6200 PLAZA MAYOR.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY		8. DATE OF BIRTH 9. AGE (In years lost birthday)	
MD.		USA.		1-8-86 78	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Lewis? Holland.			Sophia Turner		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
?		217-67-2269		Eldys Bart 2813 Winchester	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				BROUCH PNEUMONIA DAYS	
ANTECEDENT CAUSES				(B) DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CEREBRAL ARTERIO SCLEROSIS YEARS	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9 JUNE 19 65 to 10 JUNE 19 65, that (I) (we) last saw the deceased alive on 10 JUNE 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
Richard D. Bigger Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		10 June 65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
RICHARD D. BIGGER, JR.		UNIVERSITY HOSP. BALTO. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-14-65		Western Star Cem. Baltimore Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 14 1965		Robert E. Fisher		George A. Kellar 1348 N. Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

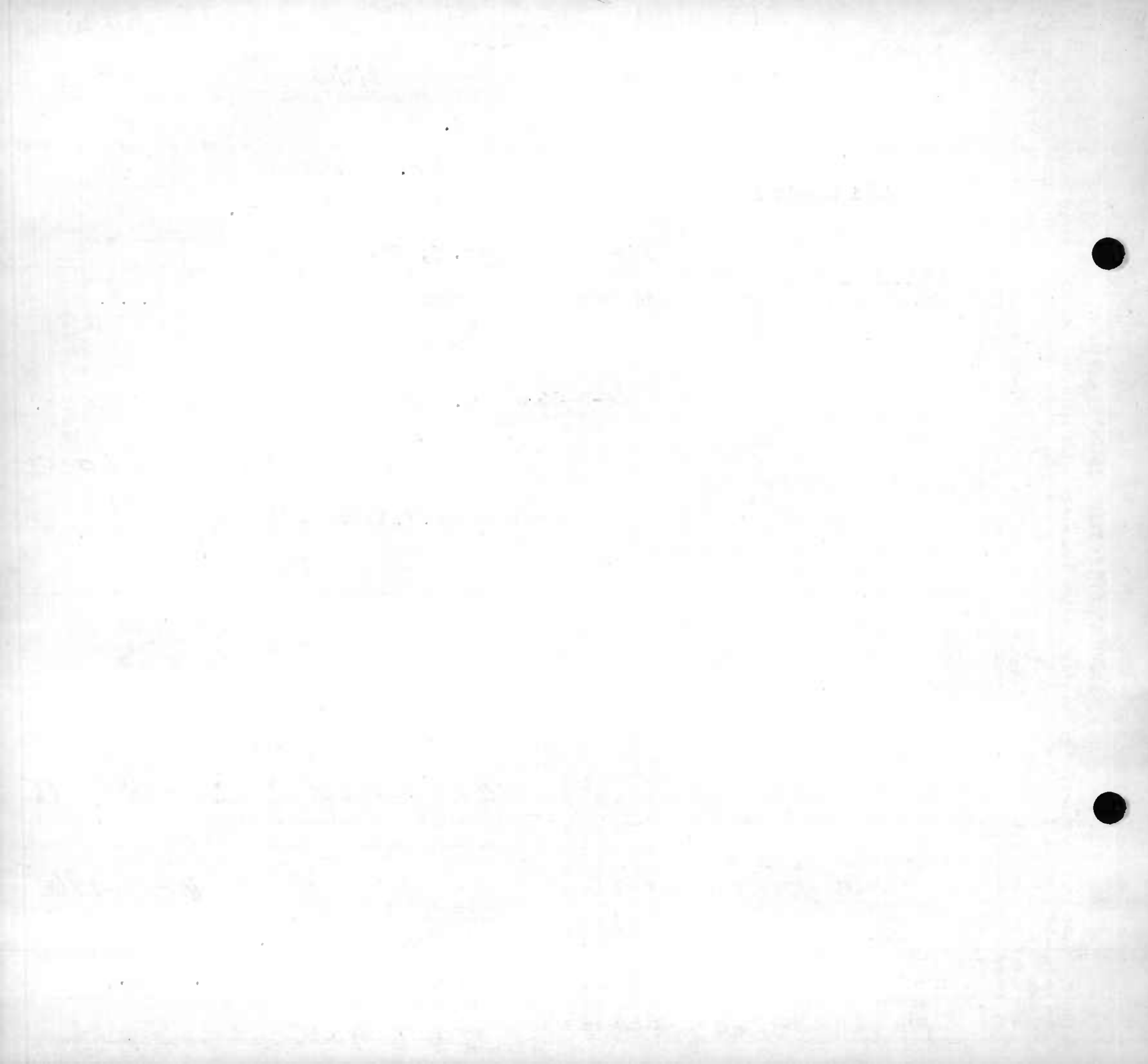
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		65 6160		65 6160	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Walter Lee Palmer				JUNE 11, 1965 945 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived; if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
University Hospital Baltimore		M		Neg		MARRIED	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
6/10/21		44		Carpenter		Ft. Meade	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
N.C.		USA		FRED PALMER		Lucinda Louick	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes		WWII		chart.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
201X I		Hodgkins Disease		4 yrs.			
ANTECEDENT CAUSES		Bronchopneumonia		5 days.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that the (this hospital) attended the deceased from 6/9 1965 to 6/11 1965, that (I) we last saw the deceased alive on 6/11 1965 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) not view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Donald T. Lewers M.D.				6/11/65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DONALD T. LEWERS				University Hospital, Baltimore			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6-16-65		Baltimore Natl. Cem.		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 14 1965		Robert E. Fairbank		Hesseltine		1348 N. Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

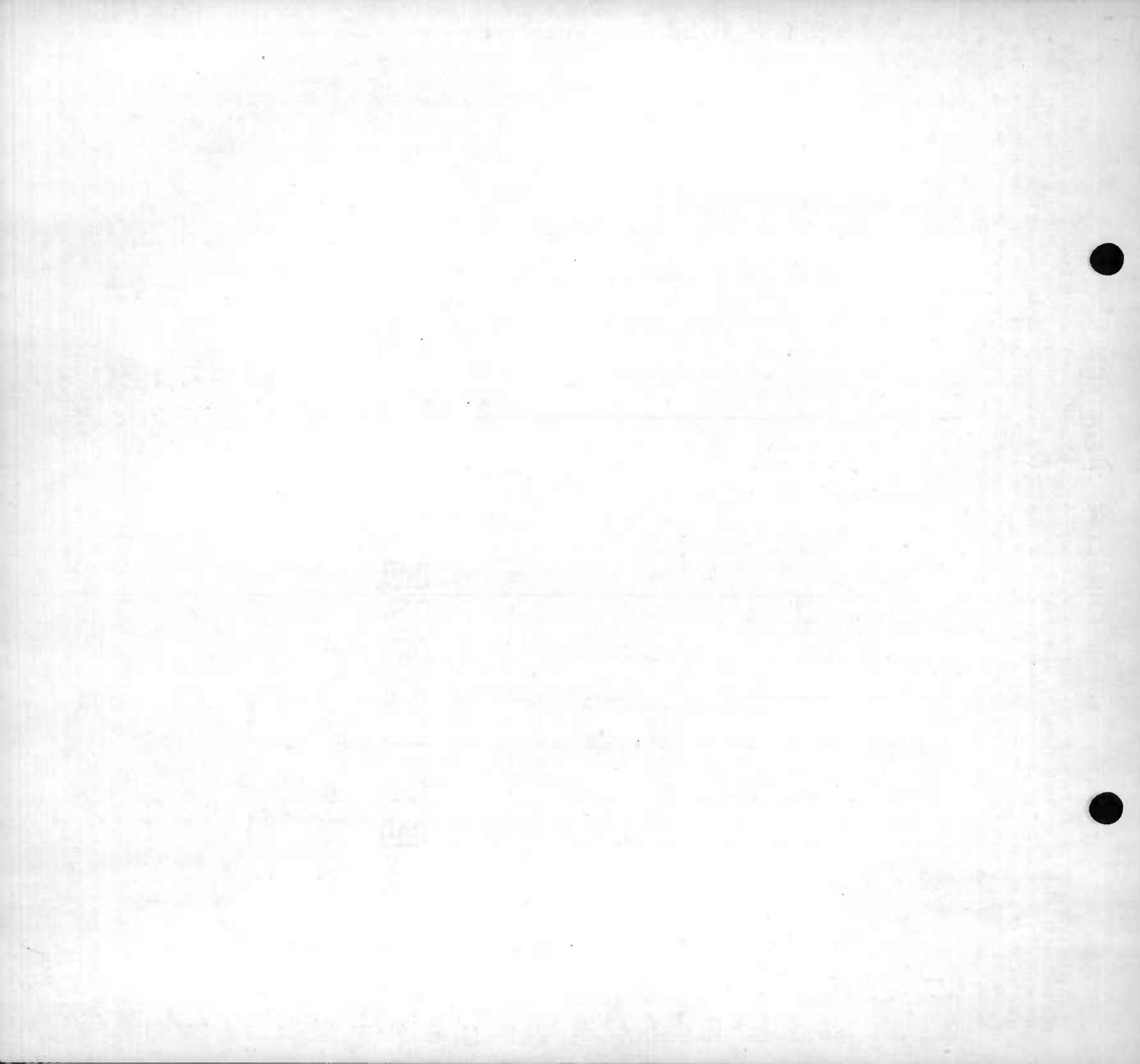
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6161	
BIRTH NO. 65 6161		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 6/8/65 5¹⁰ p M.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lester Thomas Hughes			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-18 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. 21215 D. STREET ADDRESS (If rural, give location) 4932 Park Heights Ave.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov. 5, 1896	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mutual Clerk		10B. KIND OF BUSINESS OR INDUSTRY Race Track		11. BIRTHPLACE (State or foreign country) Ohio	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Samuel Hughes			14. MOTHER'S MAIDEN NAME Artie Trease		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 265-09-1320		17. INFORMANT ADDRESS Mrs. Talitha Hughes, 4932 Park Heights Ave.	
18. 420, 1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Acute Coronary Thrombosis DUE TO (B) Arteriosclerotic heart disease DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 1 hour 2	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-27-1959 to 6-8-1965 , that (I) (we) last saw the deceased alive on 6-8-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jerome J. Blumberg		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-10-1965	
23C. PHYSICIAN'S NAME (Type) Jerome Blumberg		23D. ADDRESS M.D. 4832 Park Heights Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 6/12/65		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery	
24D. LOCATION (City, town, or county) (State) Windsor Mill Rd. Balto. Md					
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Loring Byers Funeral Home Randallstown Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

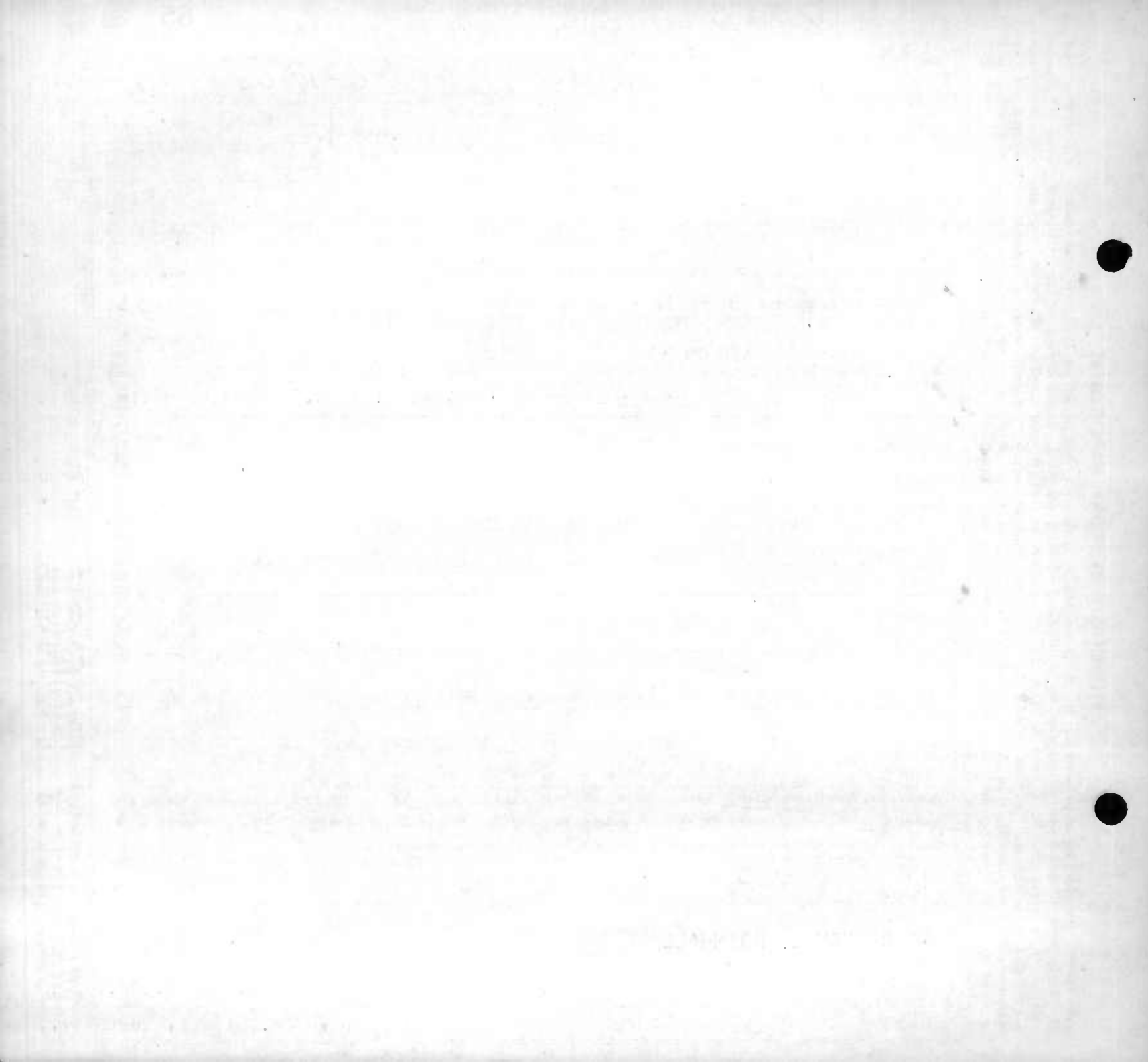
BALTIMORE CITY HEALTH DEPARTMENT				65 6162	
BIRTH NO. 65-13454 65 6162				REGISTERED NO. _____	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>EDMONDSON BABY BOY</u>				2. DATE AND HOUR OF DEATH <u>6-10-65</u> <u>1st</u> <u>A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sirai Hosp of Balto</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>15-38</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto</u> D. STREET ADDRESS (If rural, give location) <u>3712 Forest Park Ave.</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>6/5/65</u>	9. AGE (In years last birthday) <u>5</u>	If Under 1 Yr. Months <u>5</u> Days <u>16</u> If Under 24 Hrs. Hours <u>16</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>New born</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>New born</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>	
13. FATHER'S NAME <u>Robert Edmondson</u>			14. MOTHER'S MAIDEN NAME <u>Charlotte</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT <u>Mt. Robert McLes Edmondson</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <u>Respiratory Aired</u> DUE TO (B) <u>Immaturity</u> <u>wt 1305 gm</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>16</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Hyperb. I. rubrum; Hypocalcemia</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>_____</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>_____</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>_____</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>_____</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>_____</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>6/5/65</u> 19 to <u>6/10/65</u> 19 , that (I) (we) last saw the deceased alive on <u>6/10/65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>S. Seidman</u>				23B. DATE SIGNED <u>6/10/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Sidney Seidman</u>		23D. ADDRESS <u>Sirai Hosp. of Balto.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/11/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore 21133 Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 14 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Haring Payers 8728 Liberty Rd</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

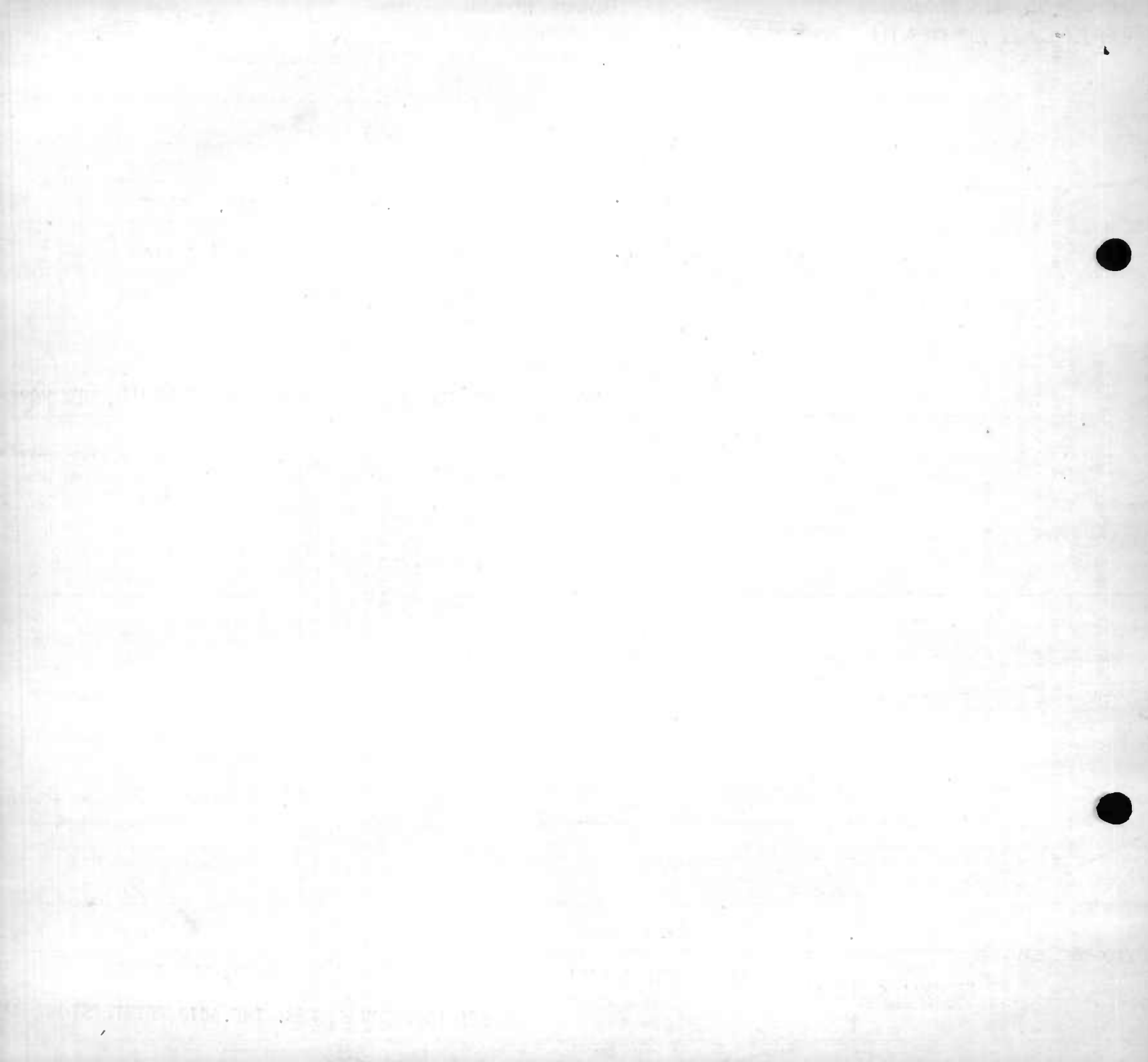
BIRTH NO. 65 6163				BALTIMORE CITY HEALTH DEPT.		Registered No. 65 6163	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) Robert B. Davids				2. DATE AND HOUR OF DEATH 6-10-65 16⁰⁵ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 12-01	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) Broadview Apts.			
5. SEX M	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 3-6-88	9. AGE (in years last birthday) 77	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Investment Analysis - Investments			10B. KIND OF BUSINESS OR INDUSTRY Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Davids.				14. MOTHER'S MAIDEN NAME LOIS HAGAR			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. (YMCA PERSONNEL) 216-28-7230		17. INFORMANT: wife Mrs. Virginia B. Davids, Broadview Apts.		ADDRESS City	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 2-days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arterio-sclerotic Cardio-vascular Disease							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 8 1965 to June 10 1965 , that (I) (we) last saw the deceased alive on June 10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Rodney L. Brimhall				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-10-65	
23C. PHYSICIAN'S NAME (Type) DR RODNEY L. BRIMHALL				23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/12/65		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Stewart & Mowen Co., 108 W. North Av.,			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65-5425	
BIRTH NO. 65-03705		6164		CERTIFICATE OF DEATH				65-5425			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Jeffrey D. Fuss				2. DATE AND HOUR OF DEATH 11:35 PM 6/7/65				M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY			
JOHNS HOPKINS HOSPITAL.						MARYLAND		Baltimore			
5. SEX						6. RACE		7. MARRIED, NEVER MARRIED		8. DATE OF BIRTH	
MALE		WHITE		WIDOWED, DIVORCED (specify)		2-13-65		INFANT, HS		9. AGE (In years last birt)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		If Under 1 Yr. Days		If Under 24 Hrs. Min.	
NONE		NONE		BALTIMORE, MARYLAND		USA		3		26	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
IRWIN FUSS						MARCIA BERENSON					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS			
NO		NO		RIVERSIDE MEMORIAL CHAPEL, BROOKLYN, NEW YORK							
18. 754.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						CAUSE OF DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)						(A) Cardiac Arrest					
ANTECEDENT CAUSES						(B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(C) Cong. Heart Disease					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
2				YES							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from June 2 19 65 to June 7 19 65, that (I) (we) last saw the deceased alive on June 7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED		
Richard H. Heller									6/8/65		
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS					
DR. RICHARD HELLER						Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
REMOVAL & BURIAL		6/9/65		BETH ISRAEL		WOODBRIDGE, NEW JERSEY					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR							
JUN 14 1965		Robert E. Farkner		SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		65 6165		CERTIFICATE OF DEATH	
2. DATE AND HOUR OF DEATH 10:40 PM 6/10/65		A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY 27-17 D. STREET ADDRESS (If rural, give location) 4852 Pimlico Road			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5/5/1884	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) METAL SORTER		10B. KIND OF BUSINESS OR INDUSTRY METAL PRODUCTS		11. BIRTHPLACE (State or foreign country) POLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, for or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 215-05-7840		17. INFORMANT daughter 4852 Pimlico Road			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I7260X		CAUSE OF DEATH (A) DUE TO possible Myocardial Infarction (B) DUE TO Arteriosclerotic Cardiovascular disease (C) _____		INTERVAL BETWEEN ONSET AND DEATH (estimate) 48 hrs 6 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 6/7/65 19 to 6/10 19 65, that (X) (we) last saw the deceased alive on 6/10/65 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Melvin J. Kordon				23B. DATE SIGNED 6/10/65	
23C. PHYSICIAN'S NAME (Type) MELVIN J. KORDON				23D. ADDRESS Sinai Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/11/65		24C. NAME OF CEMETERY or CREMATORY JEWISH NATIONAL FORBAND	
24D. LOCATION ROSEDALE		24E. (City, town, or county) MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Feltner		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	

1955-1956

1956-1957

1957-1958

1958-1959

1959-1960

1960-1961

1961-1962

1962-1963

1963-1964

1964-1965

1965-1966

1966-1967

1967-1968

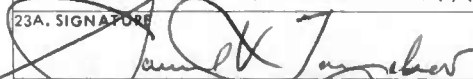
1968-1969

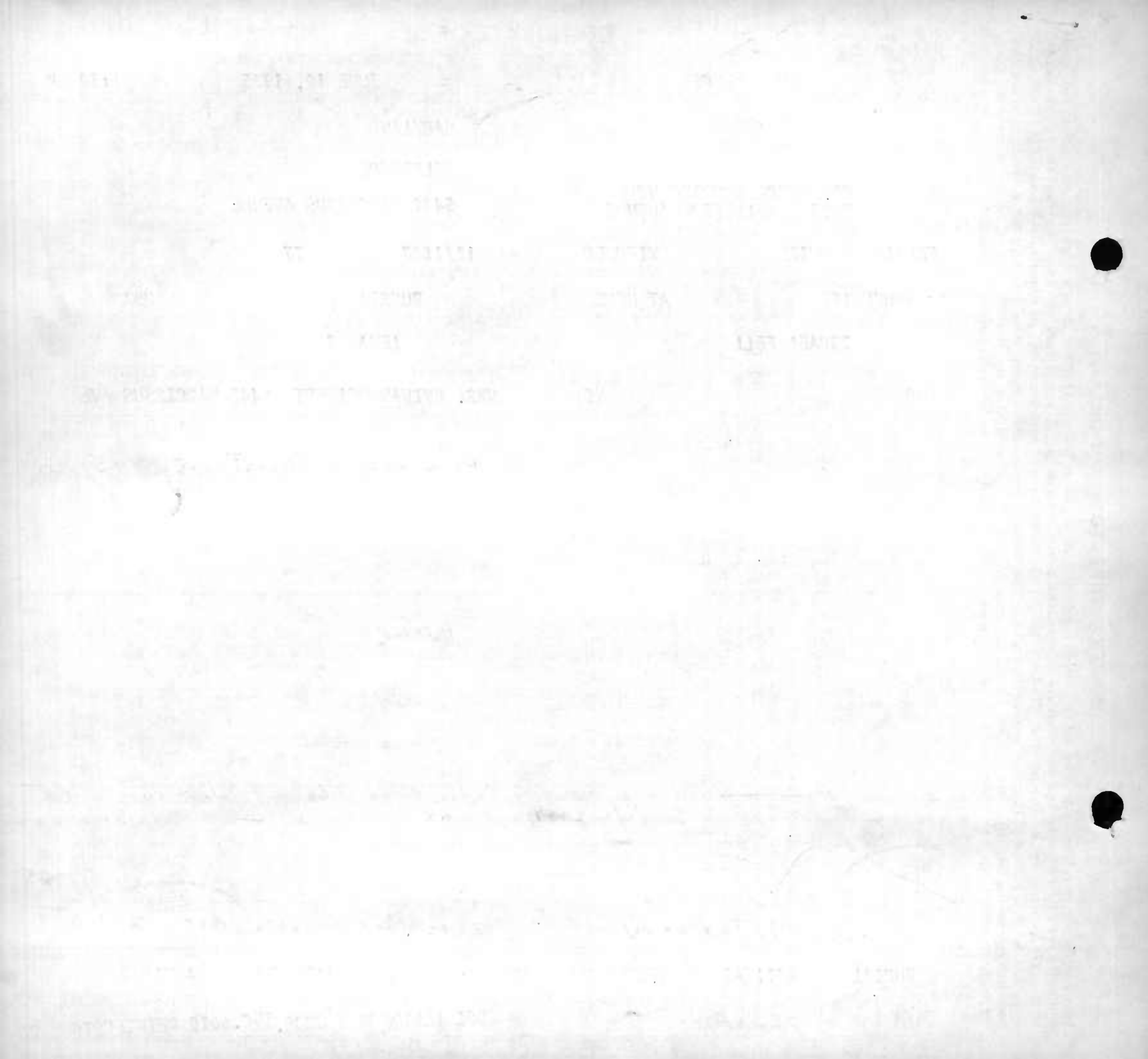
1969-1970

1970-1971

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6166		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6166	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ANNA WENDER			2. DATE AND HOUR OF DEATH JUNE 10, 1965 1:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BELVEDERE NURSING HOME 2525 W BELVEDERE AVENUE			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-18 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5442 NARCISSUS AVENUE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12/1887	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ISRAEL FELL			14. MOTHER'S MAIDEN NAME LENA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	17. INFORMANT ADDRESS MRS. SYLVAN WOLPERT 5442 NARCISSUS AVE		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 170 X I Carcinoma of the Breast, right INTERVAL BETWEEN ONSET AND DEATH 5 yrs. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. None					
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 9, 1965 to June 10, 1965 , that (I) (we) last saw the deceased alive on June 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED June 10, 1965		
23C. PHYSICIAN'S NAME (Type) SAMUEL V. TOMPAROV		23D. ADDRESS 3600 Park Heights Ave 21215			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6/11/65	24C. NAME OF CEMETERY or CREMATORY HEBREW YOUNG MEN		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
M.E. CASE NO.				CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) MILLER, ROSE				2. DATE AND HOUR OF DEATH 6-10-65 4:02 a.m.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LEVINDALE, HEBREW HOME AND INFIRMARY				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) LEVINDALE AGED HOME							
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9/8/1896	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) PHILADELPHIA, PA.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT MR. LAWRENCE MILLER		ADDRESS BUTLERVILLE ROAD SOMER, NEW YORK			
18. 433.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) massive cerebral or pulmonary infarction, probably AS H.C.V.D. with chronic atrial fibrillation.				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH 5 minutes			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from June 6 1961 to June 10 1965 , that (I) (we) last saw the deceased alive on June 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Ruth Willner				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-10-65					
23C. PHYSICIAN'S NAME (Type) RUTH WILLNER				23D. ADDRESS LEVINDALE							
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 6/11/65		24C. NAME OF CEMETERY or CREMATORY MONTIFIORE CEMETERY		24D. LOCATION (City, town, or county) (State) PHILADELPHIA, PENNSYLVANIA					
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.		ADDRESS 6010 REISTERSTOWN RD					

June 24

1880

John Wilson

John Wilson

BIRTH NO.

65 6168

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 6168

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ESTHER

POMERANTZ

2. DATE AND HOUR PRONOUNCED DEAD

June 8, 1965

9:50 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

6962 Glen Heights Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6962 Glen Heights Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

POLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

MORRIS RUBINSTEIN

14. MOTHER'S MAIDEN NAME

KAY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. JACK SIEGEL 5419 CRISMER AVENUE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
6/9/6523A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

6/10/65

23C. NAME of CEMETERY or CREMATORY

OHEL YAKOV

23D. LOCATION

(City, town, or county)

BALTIMORE

MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

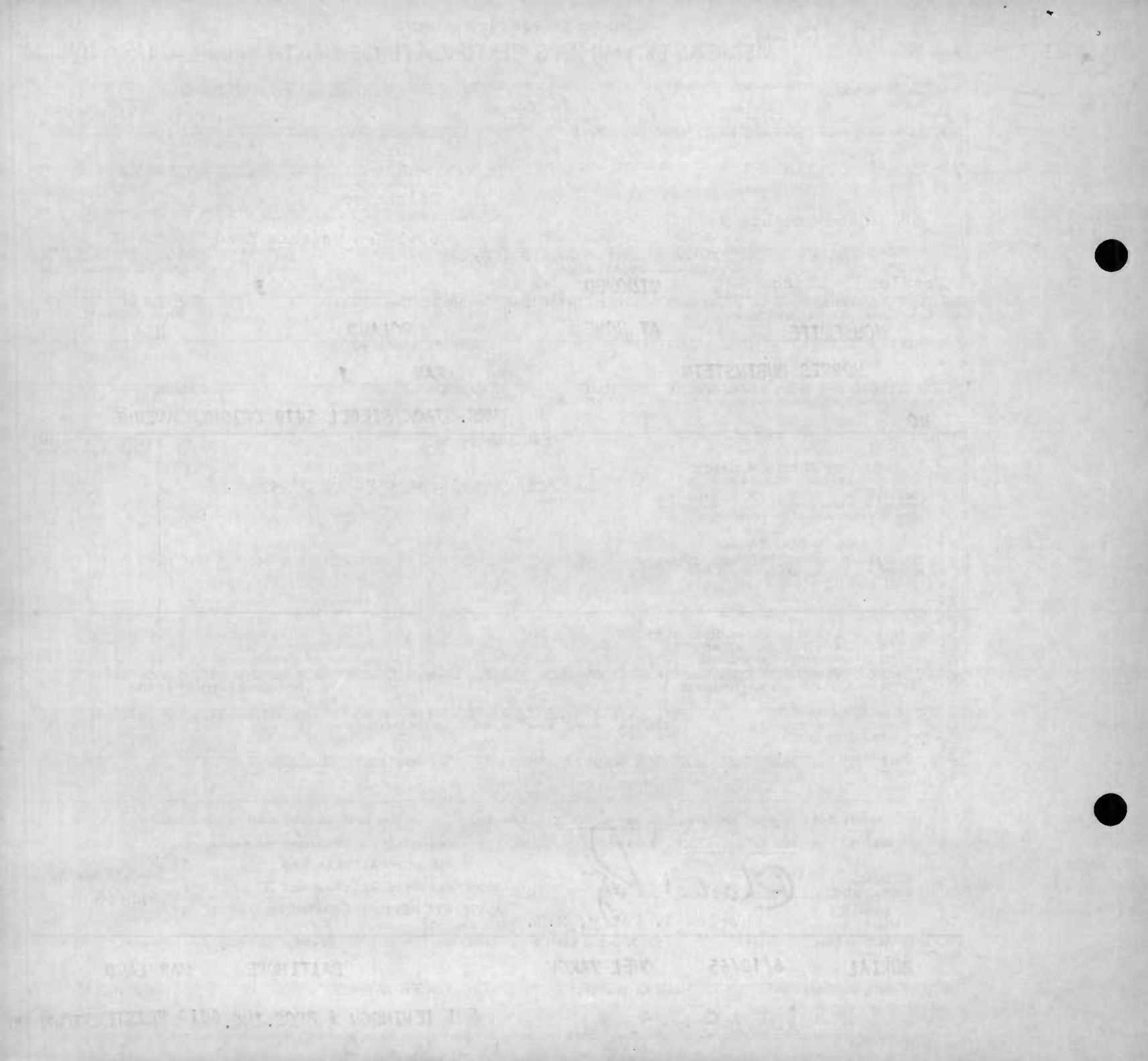
24C. FUNERAL DIRECTOR

ADDRESS

JUN 14 1965

Robert E. Taylor

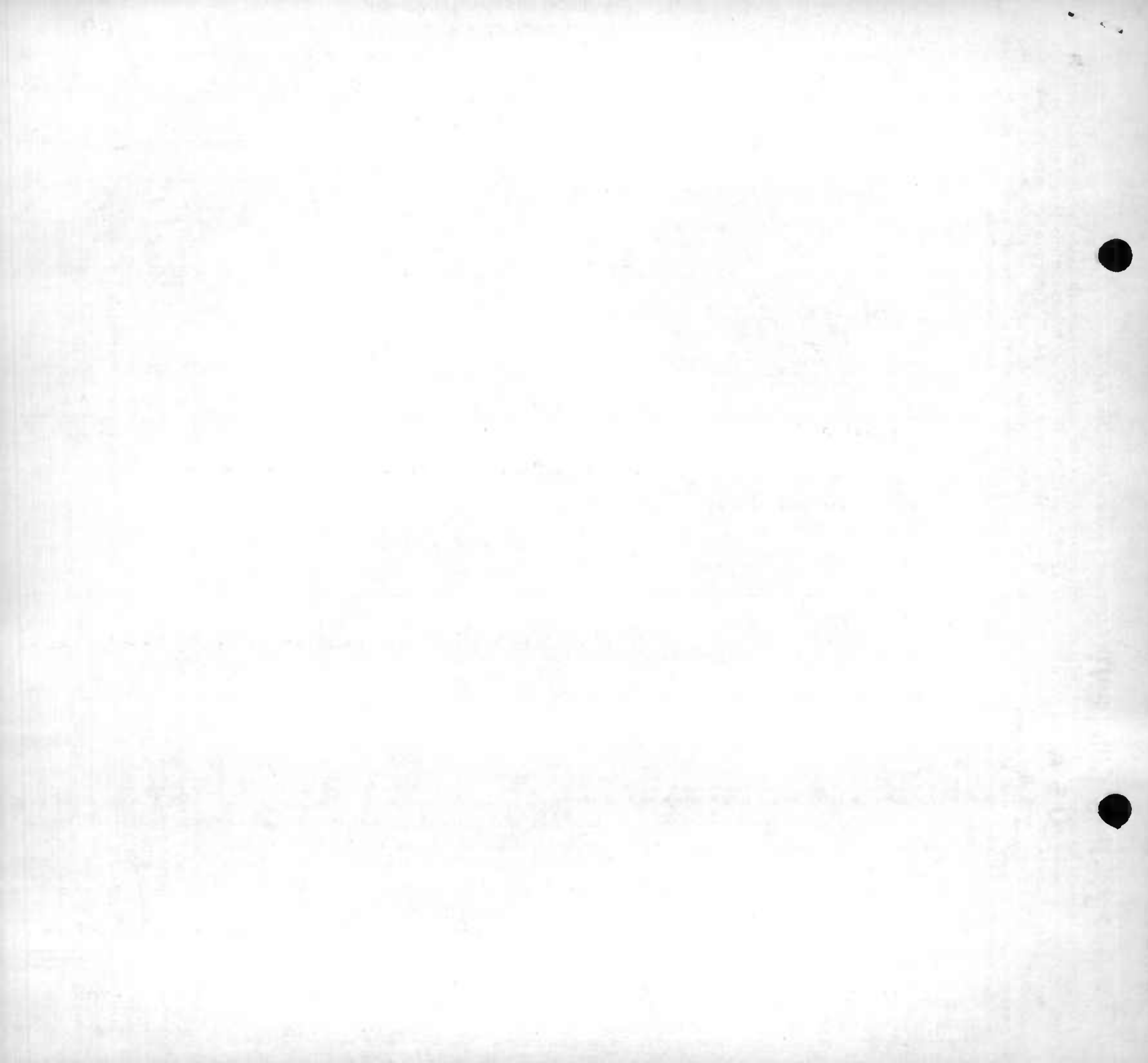
SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6169	
BIRTH NO. 65 6169		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HALPERN, REBA L.		2. DATE AND HOUR OF DEATH 6/8/65 3:45 PM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 28-31			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL, BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 4152 CRESTHEIGHTS RD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 12/23/95	9. AGE (In years lost birthday) 69	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY		10B. KIND OF BUSINESS OR INDUSTRY BAKERY		11. BIRTHPLACE (State or foreign country) AUSTRIA	
13. FATHER'S NAME ISRAEL Halpern		14. MOTHER'S MAIDEN NAME NETTIE Shear			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-01-2203		17. INFORMANT ADDRESS SISTER: SHIRLEY FLINKMAN	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Acute and Chronic Renal Failure (B) DUE TO Diabetes Mellitus (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HASCD - Congestive Heart Failure					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/3/1965 to 6/8/1965, that (I) (we) last saw the deceased alive on 6/8/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Peter A. Papantomas		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/8/65	
23C. PHYSICIAN'S NAME (Type)		M.D. 23D. ADDRESS Sinai Hospital, Balto.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/10/65		24C. NAME OF CEMETERY OR CREMATORY Bnai Israel	
				24D. LOCATION (City, town, or county) (State) Baltimore MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS Sol Levinson + Bros Inc. 6010 ROSTERTOWN RD.	



65 6170

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 6170

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Sophie Berer

2. DATE AND HOUR OF DEATH

6-8-65

3 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

823 Smoketree Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Divorced

8. DATE OF BIRTH

12-24-86

9. AGE (In years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

LIONEL TOPALER

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

NO

17. INFORMANT

ADDRESS

RECORDS-BCH-4940 Eastern Avenue - #21224

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cerebral Vascular Accident
DUE TO

instant

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) Hypertensive Arteriosclerotic
DUE TO Cerebral Vascular Disease

years

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-8 19 65 to 6-8- 19 65,
that (I) (we) last saw the deceased alive on 6-8- 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6-8-65

23C. PHYSICIAN'S
NAME (Type)

Dr. H. Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue - #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

6/10/65

24C. NAME of CEMETERY or CREMATORY

BNAI ISRAEL

24D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

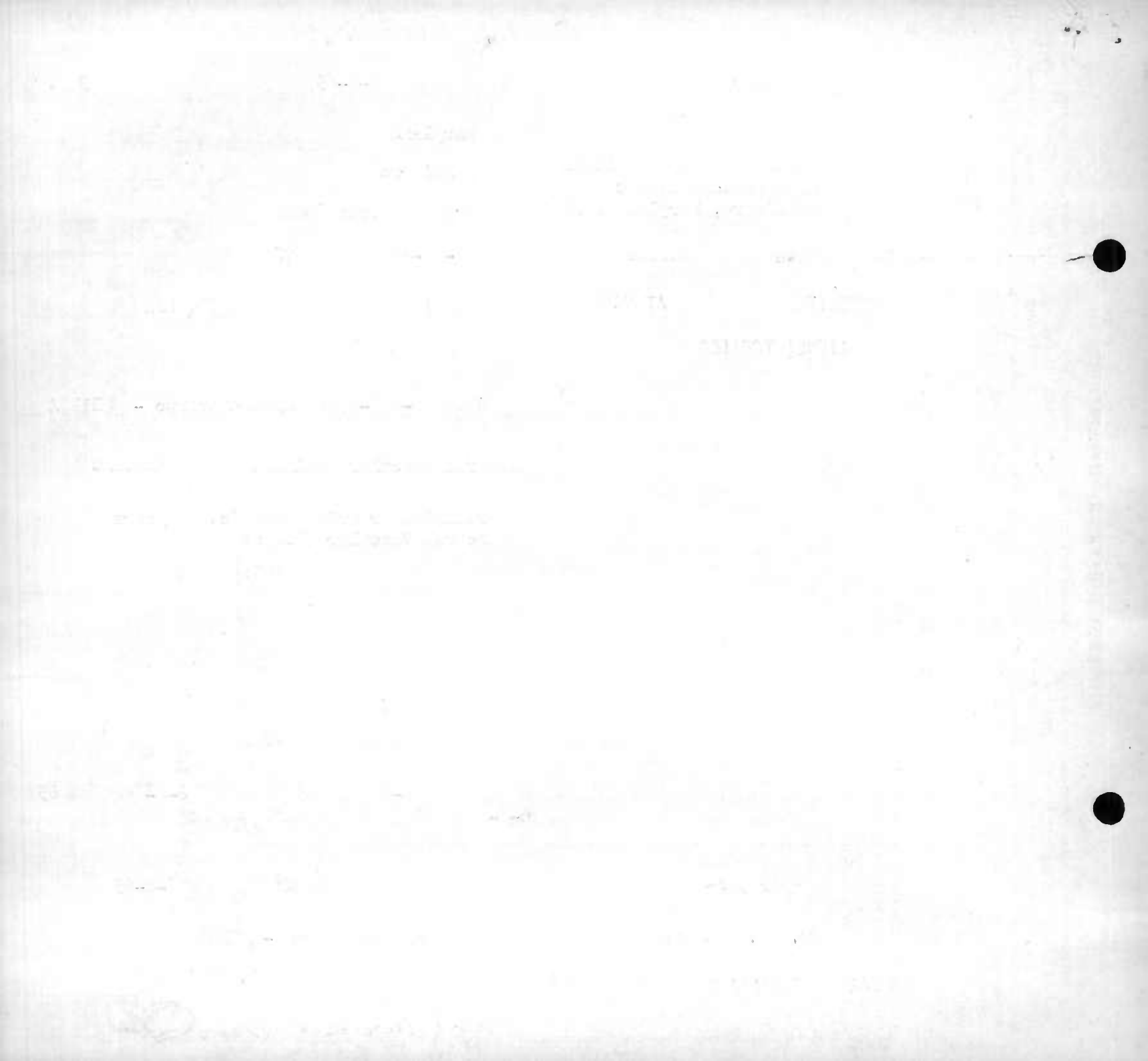
ADDRESS

JUN 14 1965

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

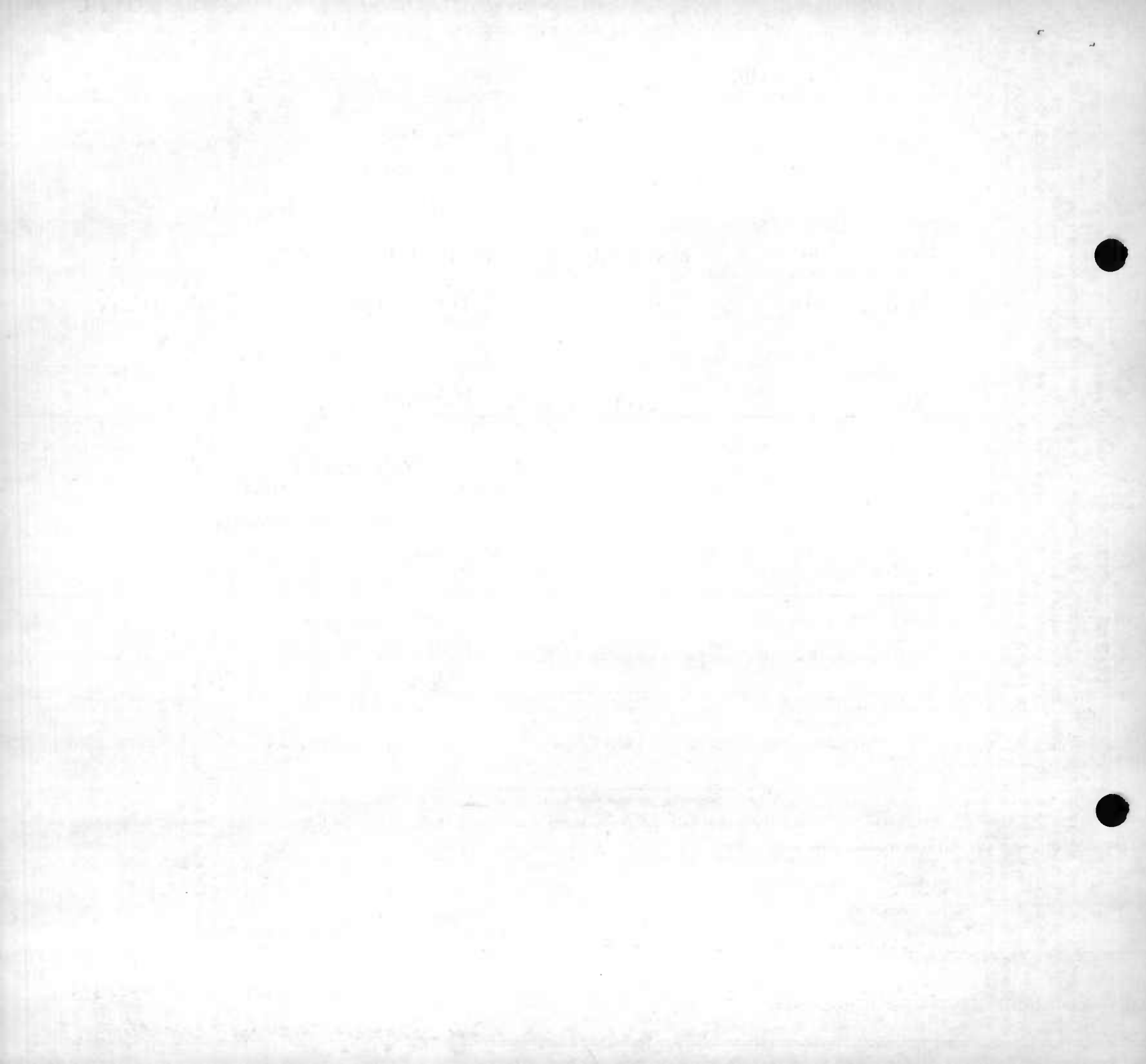
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

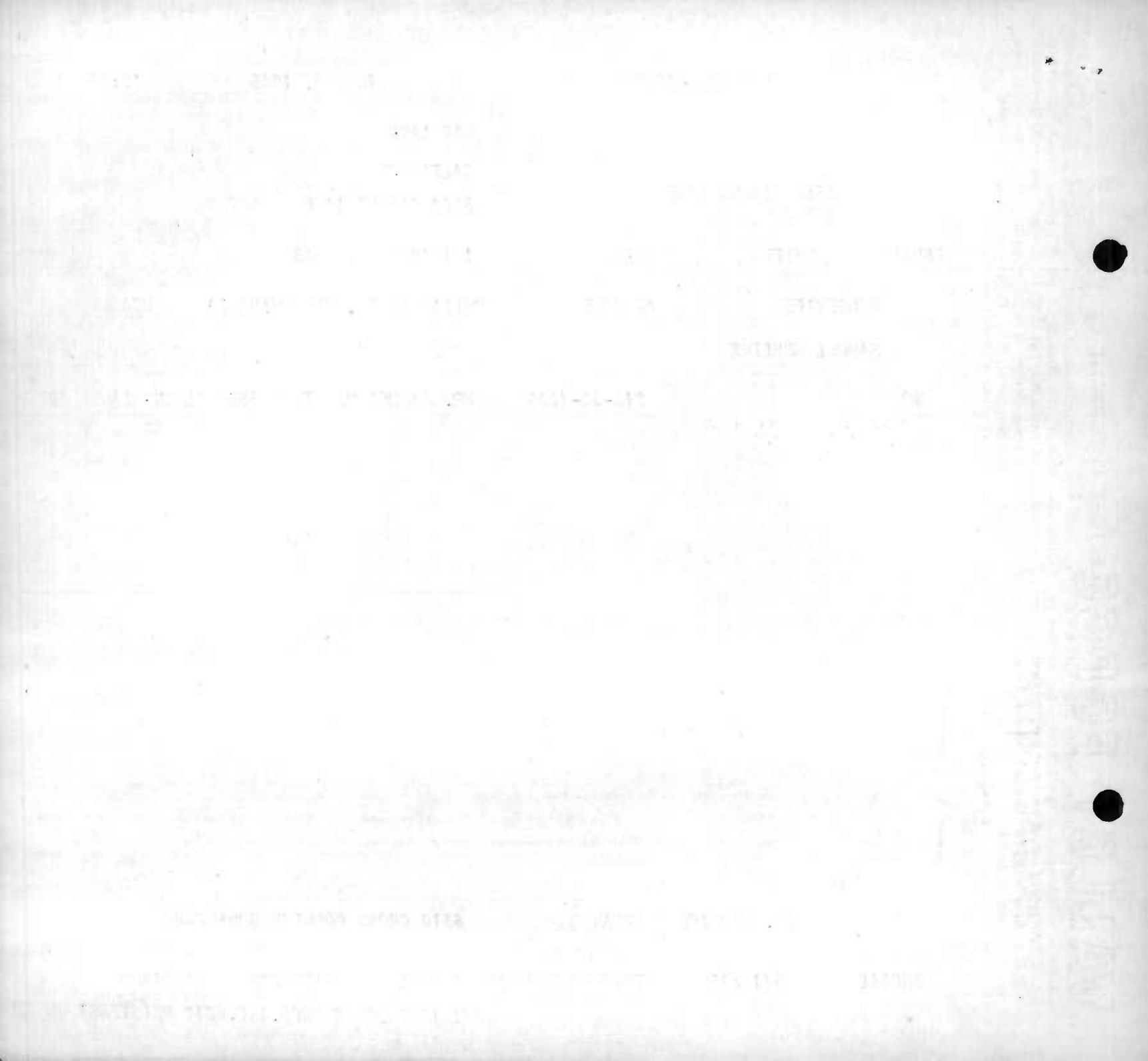
BALTIMORE CITY HEALTH DEPARTMENT				65 6171		65 6171	
CERTIFICATE OF DEATH				Registered No.			
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Daniel W. Jacobs		6-8-65 1 6 ³⁵ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
Maryland General Hospital				Maryland		15-11	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				3710 Dorchester Rd.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
Male	Cau-	Married	12-14-09	55			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Real Estate		EXECUTIVE		Maryland		USA.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
MORRIS JACOBS				ETIA FREEDEN BERG			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		217-05-1374		Patient - Hospital RECORDS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) DUE TO Coronary Occlusion & myocardial infarction			
				(B) DUE TO Arteriosclerotic cardiovascular Disease			
				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8 JUNE 1965 to 8 JUNE 1965, that (I) (we) last saw the deceased alive on 8 JUNE 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Donald M. Barwick						6/9/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DONALD M. BARWICK				M.D. MARYLAND GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		6/9/65		Bnai Israel		BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JUN 14 1965		Robert E. Jacobs		Sub LEVINSON & BEOS INC. 6010 REISTERSTOWN RD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

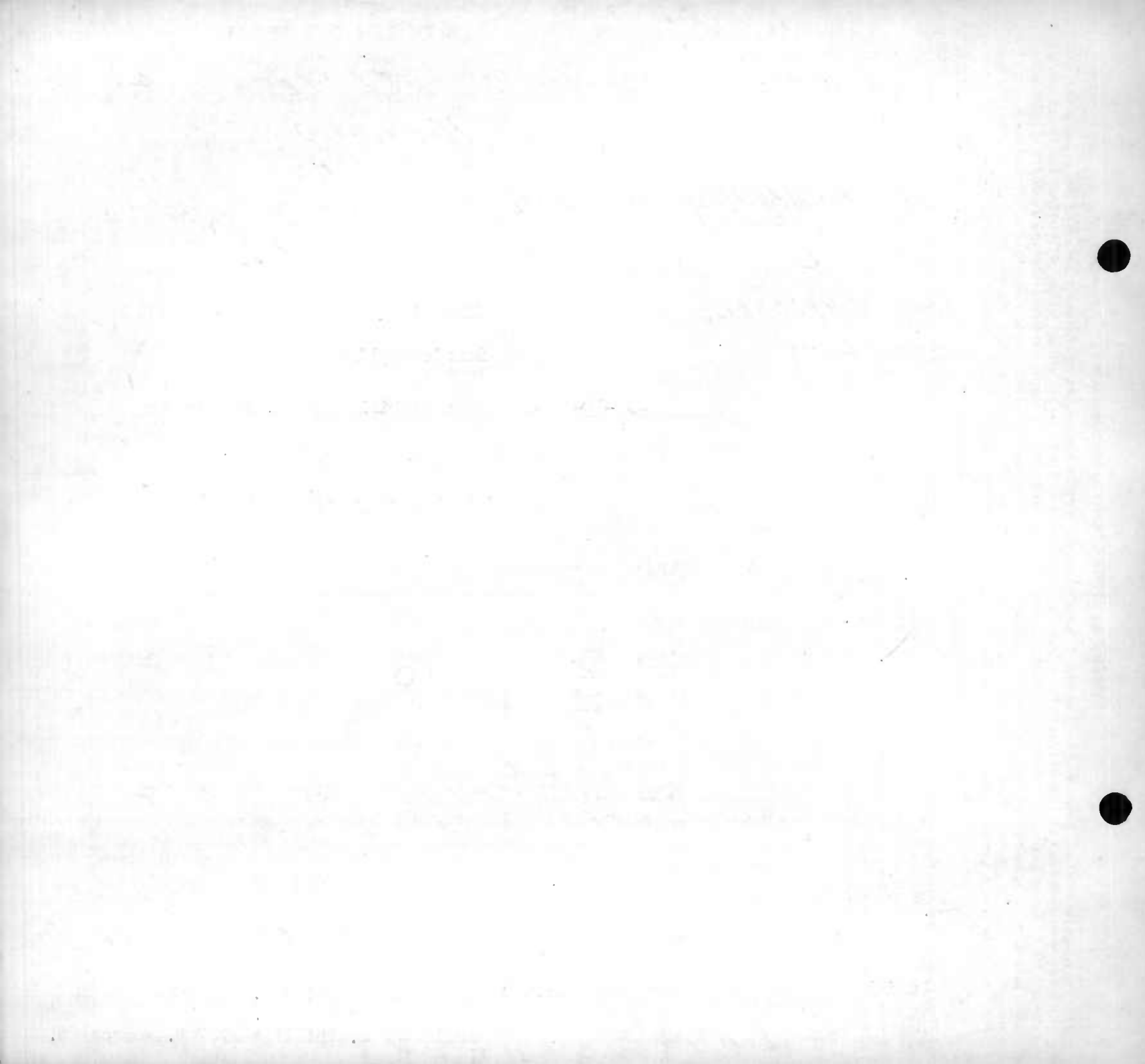
BIRTH NO. 65 6172		BALTIMORE CITY HEALTH DEPARTMENT		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6172	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) FLORENCE RICHTER				2. DATE AND HOUR OF DEATH JUNE 9, 1965 12:05 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3330 CLARKS LANE APT B				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3330 CLARKS LANE APT B			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 1/1/1902	
9. AGE (In years lost birthday) 63		10. AGE (In years lost birthday) 63		11. BIRTHPLACE (State or foreign country) PHILADELPHIA, PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY AT HOME			
13. FATHER'S NAME SAMUEL BERLINER				14. MOTHER'S MAIDEN NAME ROSE ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-32-4206		17. INFORMANT ADDRESS MR. SAMUEL RICHTER 3330 CLARKS LANE APT B			
18. 420.1 & 1260 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary occlusion art. sclerotic cardio vascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes mellitus				INTERVAL BETWEEN ONSET AND DEATH 30 min 15 yrs + 6 mth +			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) none		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/12 1960 to 6/9 1965, that (I) (we) last saw the deceased alive on 6/9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Maurice Feldman M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>						23B. DATE SIGNED 6/9/65	
23C. PHYSICIAN'S NAME (Type) DR. MAURICE FELDMAN JR M.D.				23D. ADDRESS 6610 CROSS COUNTRY BOULEVARD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/10/65		24C. NAME of CEMETERY or CREMATORY MIKRO KODESH BETH ISRAEL		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

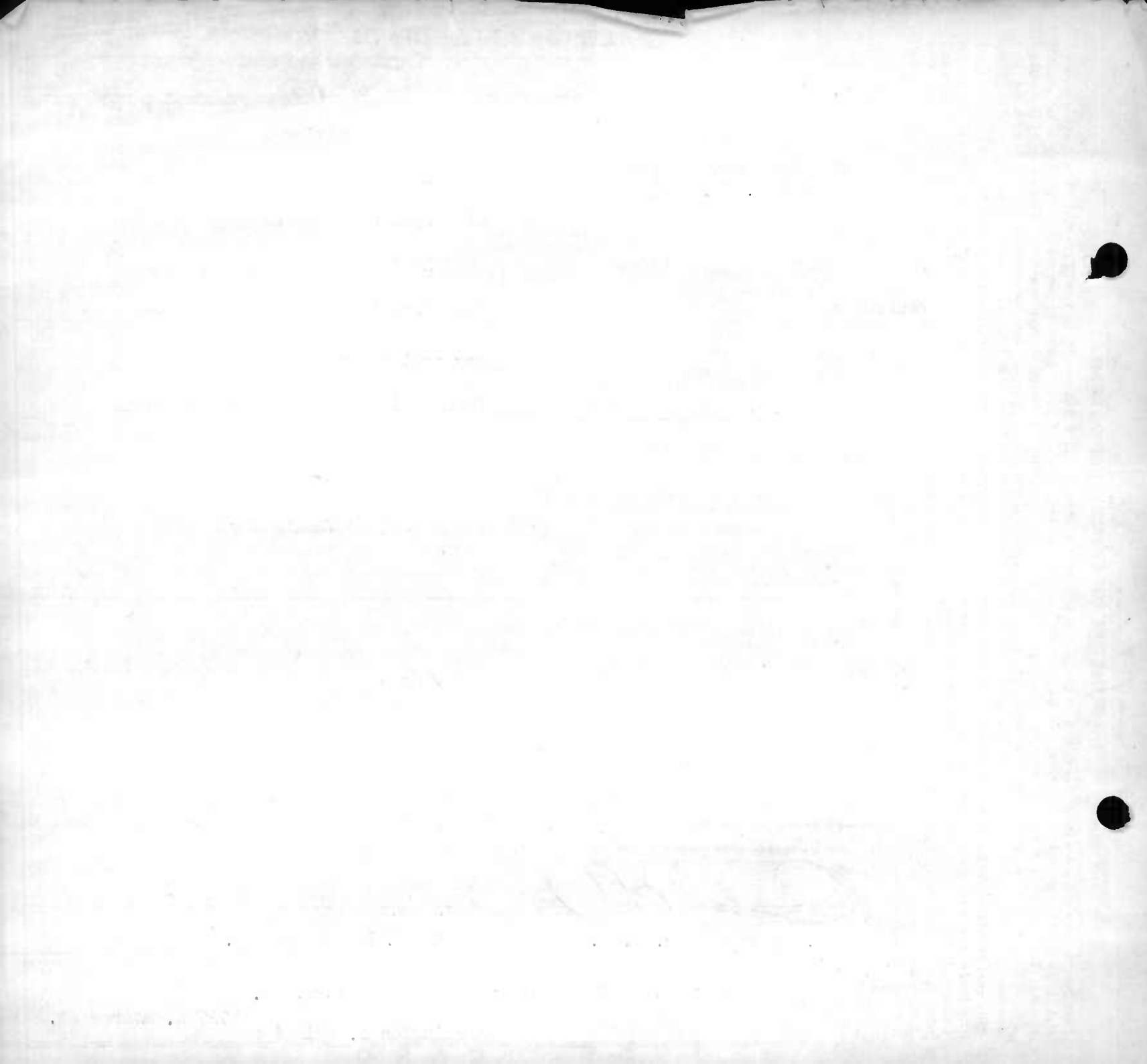
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6173	
BIRTH NO. 65 6173		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) NEWBILL GEORGE D.		2. DATE AND HOUR OF DEATH 5/9/65 4:40 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 15-03		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MD		D. STREET ADDRESS (If rural, give location) 1828 THOMAS AVE			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/22/01	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Clifton Newbill		14. MOTHER'S MAIDEN NAME Dossie English		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 235-10-4922		17. INFORMANT Edna Newbill 1828 Thomas Avenue	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MASSIVE MYOCARDIAL INFARCTION		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/31 1965 to 6/9 1965 , that (I) (we) last saw the deceased alive on 6/9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joan Sueck Lee		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/9/65	
23C. PHYSICIAN'S NAME (Type) JOAN SUECK LEE		23D. ADDRESS LUTHERAN HOSPITAL OF MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/13/65		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Arlington S. Phillips 1727 N. Monroe St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 6174		65 6174		65 6174	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Epps, Minnie			2. DATE AND HOUR OF DEATH 6/11/65 1:40 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2125 Lyndhurst Avenue Baltimore, Md. 21216			4. USUAL RESIDENCE (Where deceased lived. If institutions: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2125 Lyndhurst Avenue		
5. SEX F	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6/2/1883	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Parker			14. MOTHER'S MAIDEN NAME Margaret Howard		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	17. INFORMANT ADDRESS Thelma Wilson 2125 Lyndhurst Avenue		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Arteriosclerosis					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 10, 1965 to June 11, 1965 , that (I) (we) last saw the deceased alive on June 10, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas J. Woolridge Jr. M.D.				23B. DATE SIGNED 6-11-65	
23C. PHYSICIAN'S NAME (Type) Thomas J. Woolridge Jr. M.D.				23D. ADDRESS 703 W. Lafayette Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 6/12/65		24C. NAME OF CEMETERY or CREMATORY Lebalin Cemetery	
24D. LOCATION (City, town, or county) (State) York, Pa.					
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Farber M.D.		25C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Monroe St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6175	
BIRTH NO. 65 6175		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Edward Gross			2. DATE AND HOUR OF DEATH June 11, 1965 3:20 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1617 W. North Avenue		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH March 12, 1899	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY American Smelting	11. BIRTHPLACE (State or foreign country) St. Mary Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Robert Gross			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-10-2259	17. INFORMANT Martha Gross ADDRESS 1617 W. North Avenue		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11 Coronary Occlusion			INTERVAL BETWEEN ONSET AND DEATH 1 day		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertensive Cardiovascular Disease			Unknown		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Renal lithiasis 6 years		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 10, 1965 to June 11, 1965 , that (I) was last saw the deceased alive on June 11, 1965 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death.					
23A. SIGNATURE Charles R. Venter			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-11-65
23C. PHYSICIAN'S NAME (Type) Charles R. Venter			23D. ADDRESS M.D. 2320 E. Utah Place		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6-14-65	24C. NAME OF CEMETERY or CREMATORY Ashburton Mem. Ch.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wilmington Phillips ADDRESS 1727 N. Mo	

LS: 43-19-22

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M 332-65 6176		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6176	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Royal Montague Melvin			2. DATE AND HOUR OF DEATH June 12, 1965 7:15 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 25-32		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 134 Red Bird Avenue #21225		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 11-23-04	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John Montague			14. MOTHER'S MAIDEN NAME Sarah Carter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #21224
18. CAUSE OF DEATH					
18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 157X1			(A) DUE TO Carcinoma of Pancreas		INTERVAL BETWEEN ONSET AND DEATH 3 months
18B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO Generalized Metastasis		
			(C) DUE TO 2° to Carcinoma of Pancreas		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION April 7, 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstructive Jaundice		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 30, 1965 to June 12, 1965 , that (I) (we) last saw the deceased alive on June 12, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Don Baltzan				23B. DATE SIGNED June 12, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Donald Baltzan		23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland #24			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/15/65		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Ch. Baltimore Md.	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Arlington S. Shillig 1727 N. Monroe St.			

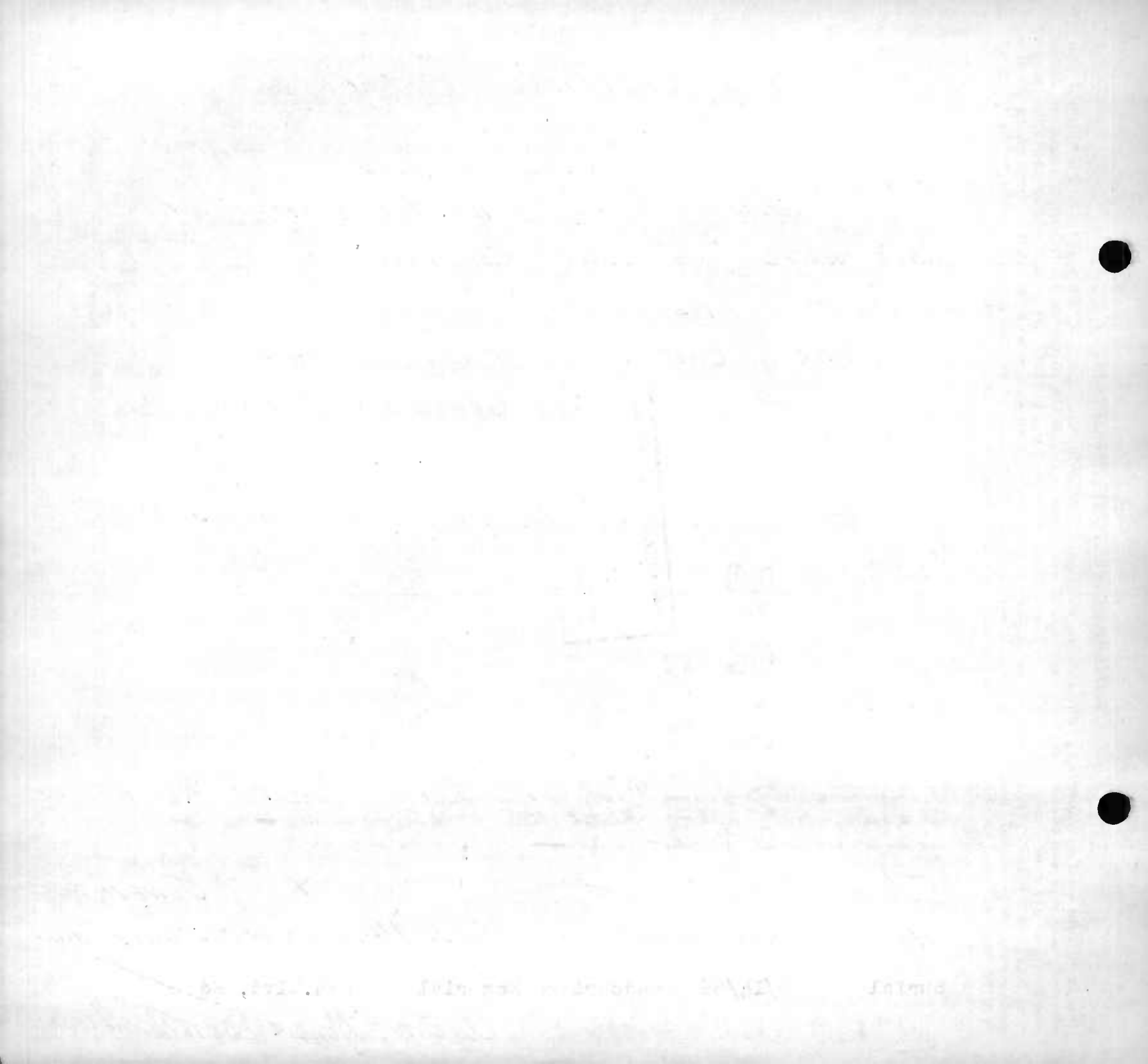
John M. Thompson
March 1st

Received of the
John M. Thompson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 6177	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
				ARTHUR CALTRIDER	
2. DATE AND HOUR OF DEATH		JUNE 10, 1965 10:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
SINAI HOSPITAL OF BALTIMORE INC. BALTO. MD (21215)		MARYLAND 27-14			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE			
D. STREET ADDRESS (If rural, give location)		1140 ROLAND HEIGHTS AVE.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
MALE	WHITE	MARRIED	JUNE 1, 1905	60	U.S.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
MACHINIST		MARTIN CO		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		17. INFORMANT	
FREDERICK A. CALTRIDER		EMMALINE KING.		GRACE L. CALTRIDER, 1140 ROLAND HEIGHTS AVE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		SECURITY NO.		ADDRESS	
NO		NO			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		COMPLETE HEART BLOCK		2 Hours	
ANTECEDENT CAUSES		ACUTE MYOCARDIAL INFARCTION		12 Hours	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 1:49 PM JUNE 10 19 65 to 10:45 AM JUNE 10 19 65, that (we) last saw the deceased alive on JUNE 10 19 65 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
HOWARD H. GENDASON				JUNE 10, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
HOWARD H. GENDASON		SINAI HOSPITAL OF BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/14/65		Meadowridge Memorial	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.			
Wash. Blvd, Md		JUN 14 1965			
25A. NAME OF REGISTRAR		25B. FUNERAL DIRECTOR		25C. ADDRESS	
Robert E. Taylor		Austin E. Sonoran		3818 Bluff Cove	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 6178		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		65 6178	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		DAISY VIOLA ARBAUGH		2. DATE AND HOUR OF DEATH		June 11, 1965 7:30 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Residence: 3300 Chestnut Av.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md.		B. COUNTY	
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced		8. DATE OF BIRTH 3/26/1889		9. AGE (In years last birthday) 76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Carroll Co. Maryland		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Marion Green		14. MOTHER'S MAIDEN NAME Clara Reese		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT: Daughter Mrs. Burnetta A. Kloid 1517 Potapisco Av.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Carcinoma of Ascending Colon with Metastasis (B) DUE TO Hypertension (C) DUE TO Peptic Ulcer		INTERVAL BETWEEN ONSET AND DEATH About 6 to 10 Months 3 months		19. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Jan 1965 to 11 June 1965, that (I) (we) last saw the deceased alive on 11 June 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.		23A. SIGNATURE L. L. Keown	
23B. DATE SIGNED 13 June 65		23C. PHYSICIAN'S NAME (Type) Dr. L. L. Keown		23D. ADDRESS 431 East Lake Ave Baltimore 12 Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/14/65	
24C. NAME OF CEMETERY or CREMATORY BETHEL		24D. LOCATION (City, town, or county) (State) Carrollton, Carroll Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR STEWART & MOWEN CO., 108 W. North Av., City 1	

11 June 1965

James L. K. Moore

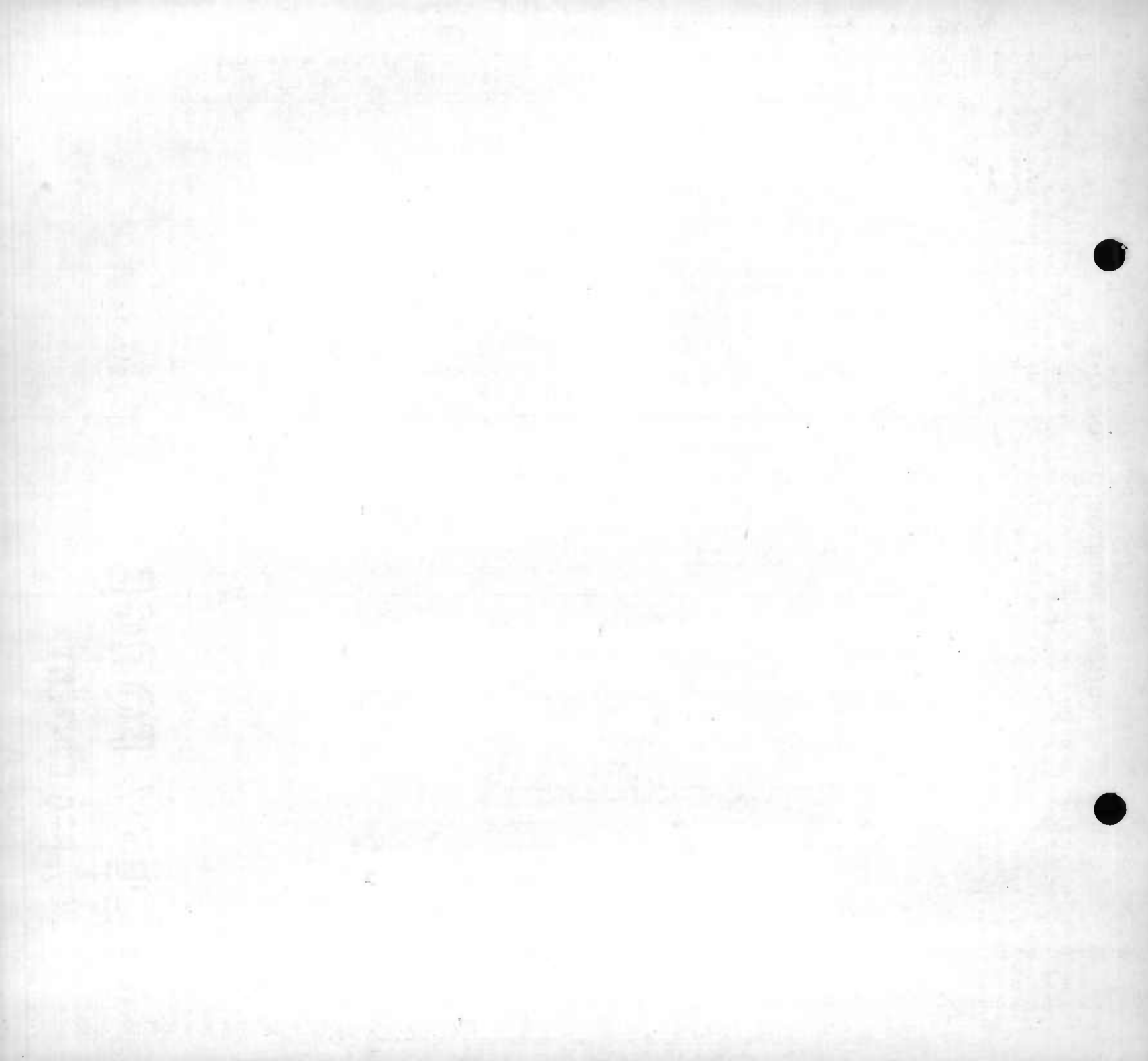
X

47/ Out for the Postman

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

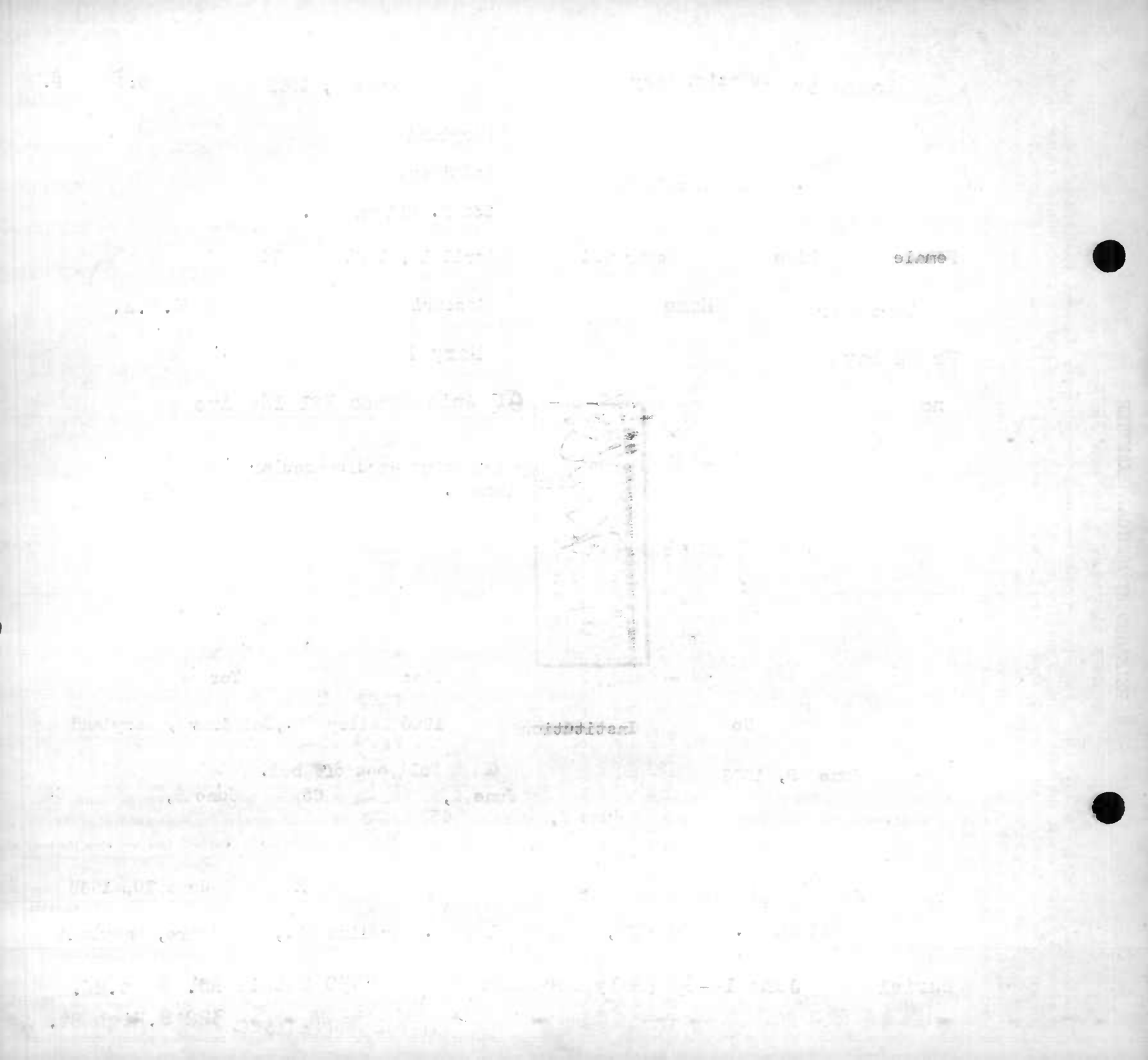
BALTIMORE CITY HEALTH DEPARTMENT		0175	
BIRTH NO. 65-13490 65 6179		CERTIFICATE OF DEATH	
M.E. CASE NO.		Registered No. _____	
1. NAME OF DECEASED (Type or Print) <u>Slaughter, Baby Boy</u>		2. DATE AND HOUR OF DEATH <u>6-9-65</u> <u>9:15</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hosp. of Balto</u>		A. STATE <u>Me</u> B. COUNTY <u>Balt City</u>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto</u>	
		D. STREET ADDRESS (If rural, give location) <u>2747 Winchester St</u>	
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>6/2/65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>7</u>
13. FATHER'S NAME <u>Ashford Slaughter</u>		14. MOTHER'S MAIDEN NAME <u>Frances A. Slaughter</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
		17. INFORMANT ADDRESS <u>2747 Winchester St. Balto. Md</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>7685T</u>		CAUSE OF DEATH <u>Pos. blood culture - Septic pneumonia</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>Sepsis -</u> DUE TO	
		(B) <u>Hypertension</u> DUE TO	
		(C) <u>Prematurely - Birth weight 1660 gm</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/2/65</u> 19 <u>65</u> to <u>6/9/65</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>6/9/65</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>S. Seidman</u>		23B. DATE SIGNED <u>6/9/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Sidney Seidman</u>		23D. ADDRESS <u>Sinai Hosp. of Balto</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-12-65</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 14 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>	
		25C. FUNERAL DIRECTOR <u>William Reese</u>	
		ADDRESS <u>Anna Mc</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 6180		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		65 6180	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
		Romeo or DeFazio, Mary		June 9, 1965		5:30		P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY			
St. Joseph Hospital				Maryland		6-02			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
				Baltimore					
				D. STREET ADDRESS (If rural, give location)					
				232 N. Milton Ave.					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months	11. If Under 24 Hrs. Days	12. If Under 24 Hrs. Hours	13. If Under 24 Hrs. Min.	
Female	White	Separated	April 15, 1891	74					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Homemaker		Home		Missouri		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Frank Bova		Mary ?							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no		219-28-9461		Anis Romeo		321 Ida Ave			
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. CAUSE OF DEATH Hypertensive cardiovascular disease.		INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				Yes		Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
No		Institution		1200 Valley St., Baltimore, Maryland					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
June 9, 1965		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		Fell out of bed.					
22. I certify that (I) (this hospital) attended the deceased from June 9, 1965 to June 9, 1965, that (I) (we) last saw the deceased alive on June 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED					
William B. VandeGrift				June 10, 1965					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS							
William B. VandeGrift		1400 N. Caroline St., Baltimore, Maryland							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		June 14-65 (Holy Redeemer)		4430 Belair Rd. Balt. Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUN 14 1965		Robert E. Taylor		Frank Dellatore		322 S. High St.			



65 6181

BALTIMORE CITY HEALTH DEPARTMENT

65 6181

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)Luigi ~~Louis~~ Masci

2. DATE AND HOUR PRONOUNCED DEAD

June 11, 1965 1:20P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3122 E. Baltimore Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

12/26-81

9. AGE (In years
last birthday)

83

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Stone mason

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Scoppito Italy

12. CITIZEN OF
WHAT COUNTRY?
Italy

13. FATHER'S NAME

Giacomo Masci

14. MOTHER'S MAIDEN NAME

Cristina Giammaria

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

215-12-9924

17. INFORMANT

ADDRESS

4 Fannie Masci 3122 E. Baltimore St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Carcinoma of pancreas

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
(If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
June 12, 196523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/15-65

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cem.

23D. LOCATION

(City, town, or county)

(State)

4430 Belair Rd.

24A. DATE REC'D BY HEALTH DEPT.

JUN 14 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Frank DellaNoce

ADDRESS

322 S. High St.

WALLEY HORTON

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Elva Louise Zapf

2. DATE AND HOUR PRONOUNCED DEAD

June 11, 1965

4:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

122 N. Highland Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

October 21, 1924

9. AGE (In years
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William E. Stumpf

14. MOTHER'S MAIDEN NAME

Louise Storath

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

218-18-9013

17. INFORMANT

ADDRESS

Mr. Robert P. Zapf 122 N. Highland Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 12, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/15/1965

23C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUN 14 1965

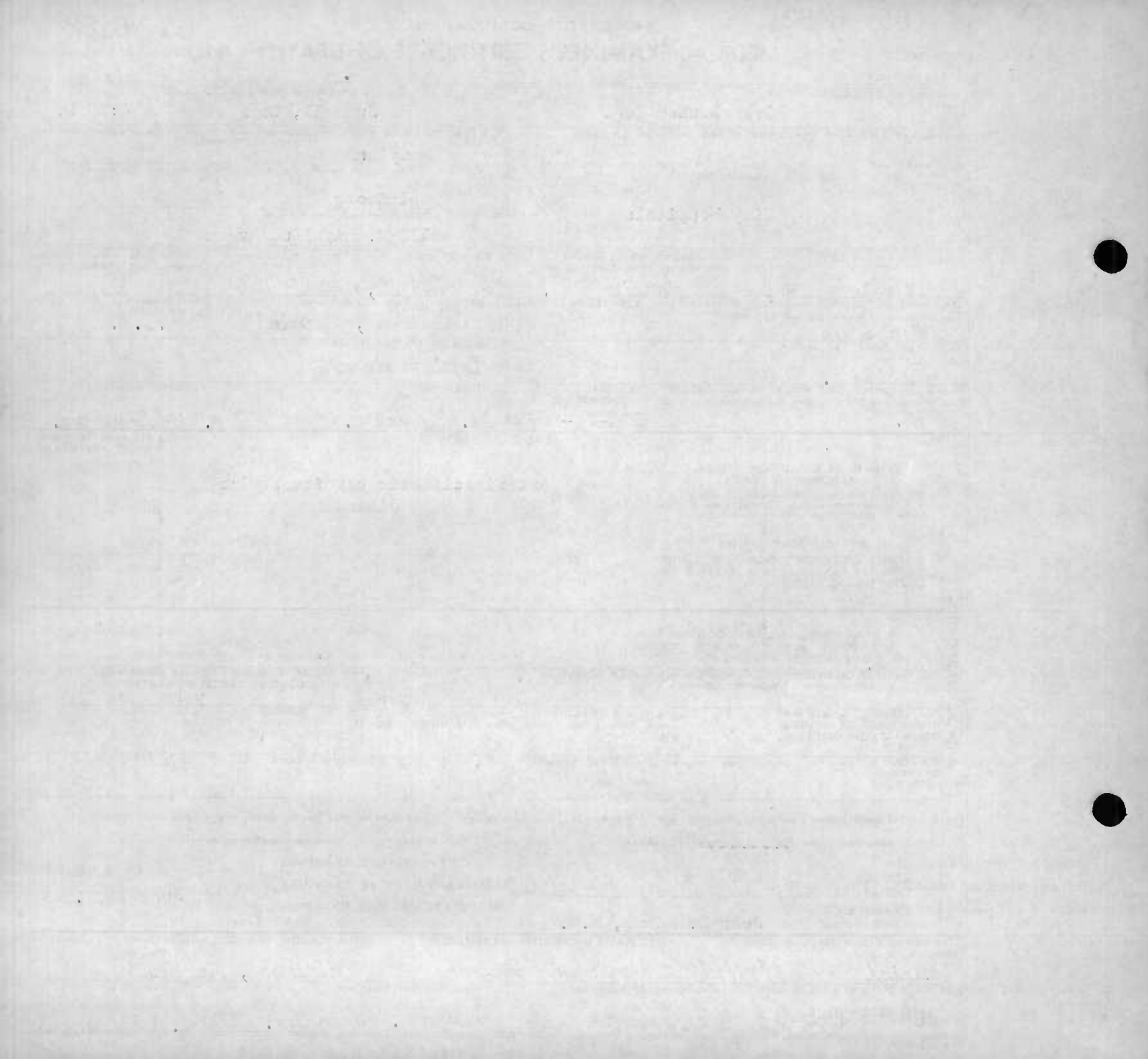
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

John A. Moran Inc. 3000 E. Baltimore St



1
Good

65 6183

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 6183

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JACQUELINE GEE		2. DATE AND HOUR PRONOUNCED DEAD June 8, 1965 8:26 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SOUTH BALTIMORE GENERAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 22-01 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 824 S. Hanover Street	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 3/25/48
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 17
13. FATHER'S NAME Summel Gee		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Rosaline Boone	
17. INFORMANT Beatrice Jackson		ADDRESS 824 S. Hanover St	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.21 Acute massive pulmonary embolism INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Interstitial myocarditis, chronic, active OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Yes 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE John E. Adams M.D. CHIEF MEDICAL EXAMINER EXAMINER'S NAME (Type) John E. Adams, M.D. ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER DATE SIGNED 6-8-65			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE 6-12-65	23C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park	23D. LOCATION (City, town, or county) (State) Arbutus, Balto. Co. Md.
24A. DATE REC'D BY HEALTH DEPT. JUN 14 1965	24B. NAME OF REGISTRAR Robert E. Farkley	24C. FUNERAL DIRECTOR ADDRESS Charles A. Rice, 661 W. Barre St.	

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WALLACE



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED
(Type or Print)

Thelma King

2. DATE AND HOUR PRONOUNCED DEAD

June 12, 1965

9:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

912 Mc Kean Ave.

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

3/11/05

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Austin

14. MOTHER'S MAIDEN NAME

Mary M. White

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mary Pitts 912 McKean Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Carcinomatosis

DUE TO carcinoma of ovary

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 13, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/18/65

23C. NAME OF CEMETERY or CREMATORY

Antioch

23D. LOCATION

(City, town, or county)

(State)

Lynchburg, Virginia

24A. DATE REC'D BY HEALTH DEPT.

JUN 14 1965

24B. NAME OF REGISTRAR

Robert E. Falkner

24C. FUNERAL DIRECTOR

ADDRESS

Charles A. Rice 661 W. Barre St.

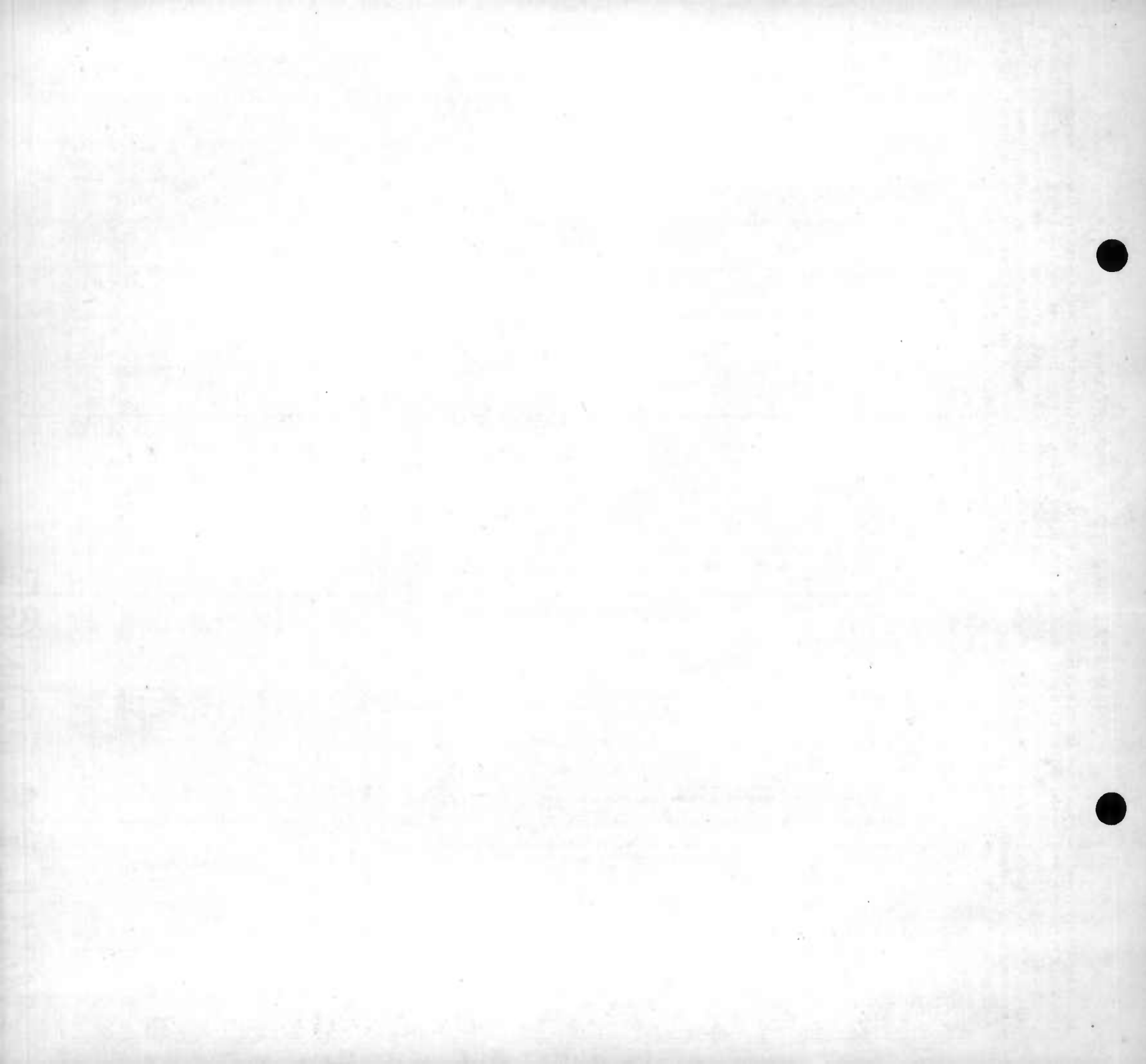
WALTER E. HOPKINS

THE UNIVERSITY OF CHICAGO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6185				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6185	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SATCHELL, ALFRED RICHARD				2. DATE AND HOUR OF DEATH 13 June 65 4:25 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		(If not in hospital or institution, give street address or location)		A. STATE MD.		B. COUNTY 44	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) LINTHICUM HEIGHTS 62-00			
				D. STREET ADDRESS (If rural, give location) ANDOVER Rd. and HARRISON AVE.			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-1-86	9. AGE (In years lost birthday) 79	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AMOS SATCHELL				14. MOTHER'S MAIDEN NAME LAURA HAMPTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-01-7982		17. INFORMANT Eliza Satchell, Linthicum Heights, Md.		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARCINOMATOSIS CARCINOMA OF COLON				INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 6-9-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-9-65 to 6-13-65, that (I) (we) last saw the deceased alive on 6-12-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Roman Herman				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-13-65	
23C. PHYSICIAN'S NAME (Type) ROMAN HERMAN				23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-16-65		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR R. E. Taylor, M.D.		25C. FUNERAL DIRECTOR Charles A. Rice, 661 W. Barre St		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6186	
BIRTH NO. 65 6186 M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Charles H. Edwards		2. DATE AND HOUR OF DEATH June 8/65			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2425 W. North Ave.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Ma. B. COUNTY 15-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2425 W. North Ave		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH July 17, 1875	9. AGE (In years lost birthday) 89	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY B. & O. R. R.		11. BIRTHPLACE (State or foreign country) Baltimore, Ma.	
13. FATHER'S NAME -----Edwards			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. John Wetzler, 414 S. Augusta Ave.	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO Bronchopneumonia (B) DUE TO (C) generalized Arteriosclerosis		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH Several days Many years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 4:23 19 65 to 6-8 19 65, that (I) the lost saw the deceased alive on 5-25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Abraham Goldman				23B. DATE SIGNED 6/10/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/11/65		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Balto. 29, Ma.		25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965			
25B. NAME OF REGISTRAR R. E. F. F. F.		25C. FUNERAL DIRECTOR ADDRESS W itzke F.D. 4101 Edmondson Ave			

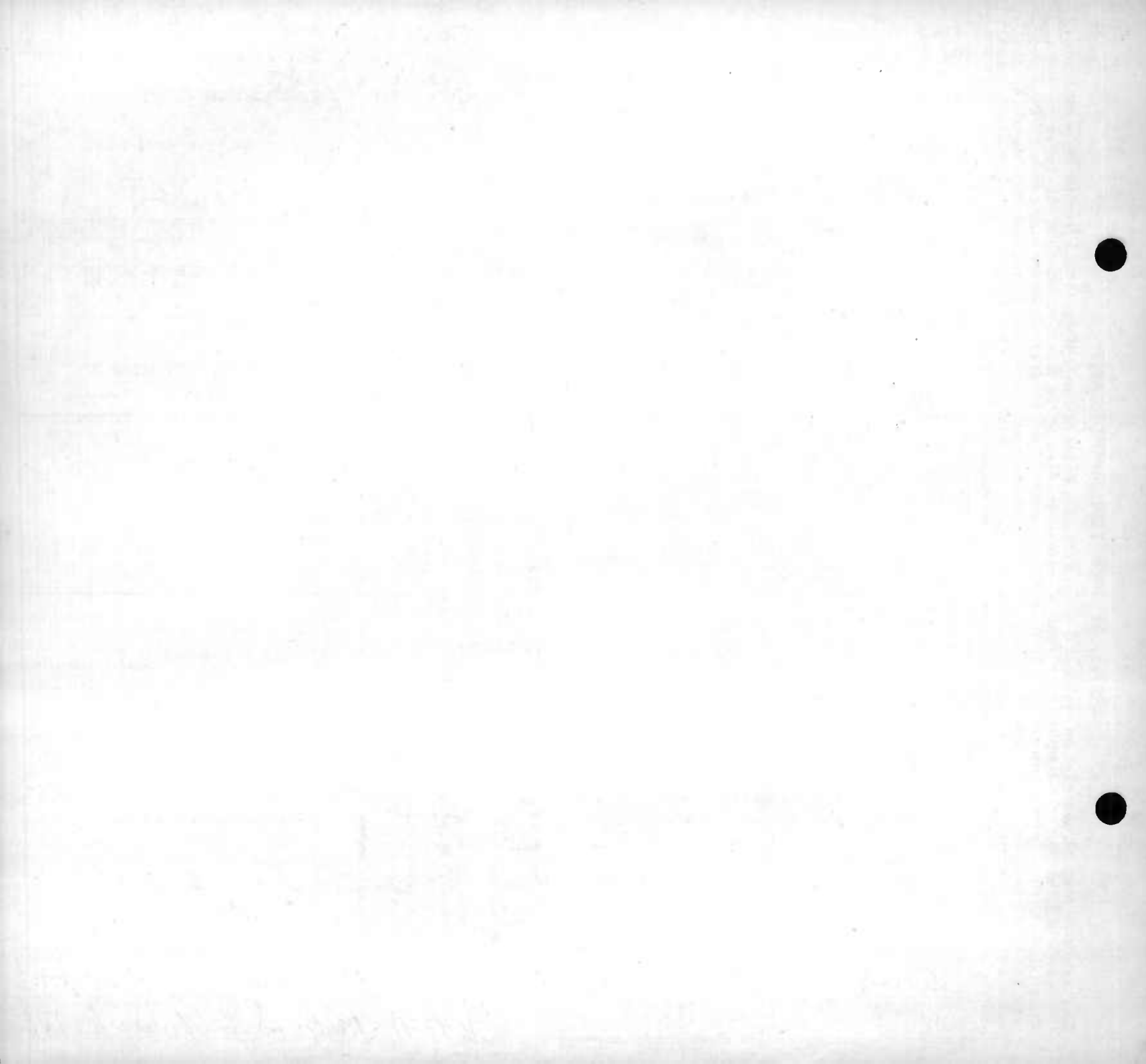
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6187		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6187	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ETHEL J. HARRISON		2. DATE AND HOUR OF DEATH 6.7.65 6.35 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL, BALTIMORE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 00 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Annapolis 52-10 D. STREET ADDRESS (If rural, give location) 412 Jefferson Street			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M.	8. DATE OF BIRTH 12.3.16	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10B. KIND OF BUSINESS OR INDUSTRY Super market		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME George Evans		14. MOTHER'S MAIDEN NAME Cora Ford		17. INFORMANT Husband, James Harrison same	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		ADDRESS	
18. 330X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebral aneurysm, ruptured DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 14 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 8/3/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Trapping cerebral aneurysm		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5.24 1965 to 6.7 1965 , that (I) (we) last saw the deceased alive on 6.7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thavatchai Fuangvudhiran M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-8-65	
23C. PHYSICIAN'S NAME (Type) THAVATCHAI FUANGVUDHIRAN M.D.		23D. ADDRESS University Hospital, Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6/11/65	24C. NAME OF CEMETERY or CREMATORY Hillcrest		24D. LOCATION (City, town, or county) (State) Annapolis Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR John M. Taylor & Sons Annapolis, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6188				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6188	
M.E. CASE NO.				CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) MRS. ETHEL RANDLETT BRAUER				2. DATE AND HOUR OF DEATH JUNE 10, 1965 12²⁰ P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Va B. COUNTY HENRICO			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township) RICHMOND, VIRGINIA			
				D. STREET ADDRESS (If rural, give location) 4412 CUTSHAW ST.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 12-9-96	9. AGE (In years lost birthday) 68	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) RICHMOND VA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM O. RANDLETT				14. MOTHER'S MAIDEN NAME KATHERINE CHEASEA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT GRACE B. POTTER	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 5994.0				CAUSE OF DEATH (A) DUE TO BRAIN STEM COMPRESSION (B) DUE TO SUBDURAL HEMATOMA (C) DUE TO and cerebral contusions		INTERVAL BETWEEN ONSET AND DEATH 36 hr. 48 hr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION JUNE 9, 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTRACEREBRAL HEMATOMA		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) X		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ANNAPOLIS, MD		52-00	
21D. TIME OF INJURY (APPROX.) UNKNOWN		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? NO DOCUMENTATION OF INJURY - ONLY BRUISES - @ ARM APPAR. FALL			
22. I certify that th (this hospital) attended the deceased from JUNE 9 19 65 to JUNE 10 19 65 , that th (we) last saw the deceased alive on JUNE 10 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. th (We) (did) (did not) view the body after death.							
23A. SIGNATURE Lincoln Jeanes, Jr.						23B. DATE SIGNED 10 June '65	
23C. PHYSICIAN'S NAME (Type) LINCOLN JEANES, JR.				23D. ADDRESS 601 N BROADWAY BALTIMORE MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-12-65		24C. NAME OF CEMETERY or CREMATORY HOLLYWOOD		24D. LOCATION (City, town, or county) (State) RICHMOND Va.	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR JOHN M. TAYLOR & SONS		ADDRESS ANNAPOLIS MD.	

WIDOW

WILLIAM O RANDETT

no

RICHMOND L A U S

KATHERINE CHESER

1950 DE
Annapolis, MD

RECEIVED

1950 DE 1

1950

1950 DE 1

1950 DE 1

John M. Tipton, Sec: Annapolis, MD

FUNERAL DIRECTOR: IMPORTANT

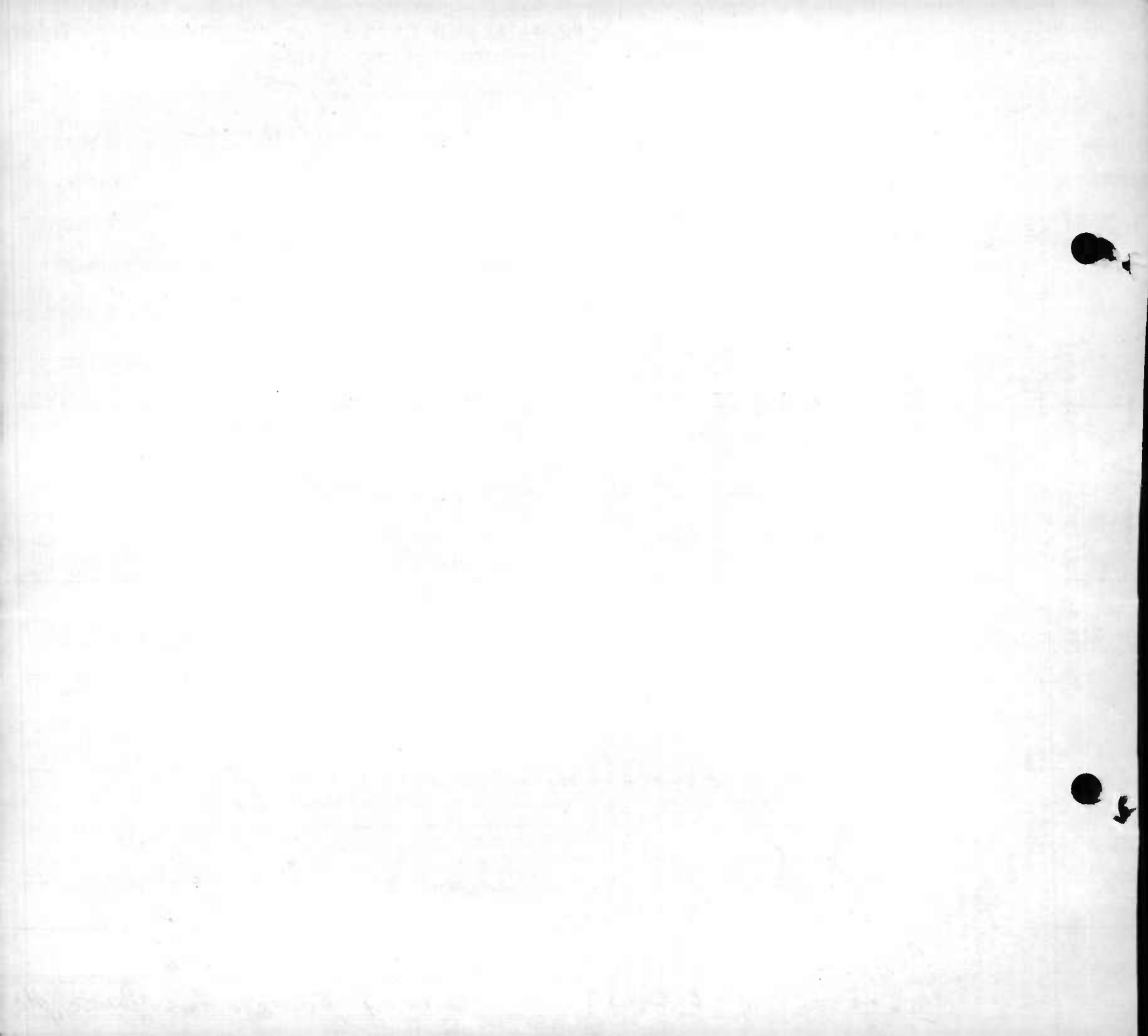
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 6189		CERTIFICATE OF DEATH		65 6189	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		William Robert Browning, Sr.		June 13, 1965 7:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 27-01	
Union Memorial Hospital		C. CITY OR TOWN Baltimore		D. STREET ADDRESS (If rural, give location) 4414 Belair Road	
5. SEX Male	6. RACE Cauc	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6-21-09	9. AGE (In years last birthday) 55	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William John Browning		14. MOTHER'S MAIDEN NAME Nora Cranford		12. CITIZEN OF WHAT COUNTRY? United States	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 215-07-3123		17. INFORMANT Pts adm History chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11		CAUSE OF DEATH Acute Myocardial infarction 12h		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 13 1965 to June 13 1965, that (I) (we) last saw the deceased alive on June 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles T. Fletcher		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 13 1965	
23C. PHYSICIAN'S NAME (Type) CHARLES T. FLETCHER		23D. ADDRESS Union Memorial Hospital			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/17/65		24C. NAME OF CEMETERY or CREMATORY PARKWOOD CEMETERY	
				24D. LOCATION (City, town, or county) (State) PARKVILLE MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ULLRICH FUNERAL HOME 4210 BELAIR RD	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 6190					CERTIFICATE OF DEATH			Registered No. 6190	
1. NAME OF DECEASED (Type or Print) <i>Harry Bremer</i>					2. DATE AND HOUR OF DEATH <i>6/9/65 13³⁰ A M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i>					A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 63-00</i>				
D. STREET ADDRESS (If rural, give location) <i>7778 Norbush Ave</i>									
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED NEVER MARRIED <i>Married</i>		8. DATE OF BIRTH <i>9/5/16</i>	9. AGE (In years last birthday) <i>48</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Armco</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>STEEL</i>		11. BIRTHPLACE (State or foreign country) <i>Balto.</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Henry Bremer</i>					14. MOTHER'S MAIDEN NAME <i>Mary Helal</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES WWII</i>					16. SOCIAL SECURITY NO.		17. INFORMANT <i>MRS. MARGARET BREMER</i>		
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cardiac Arrhythmia</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Myocardial infarct old & Recent</i> <i>ASCVD</i>					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH <i>Recent</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>mild HBP.</i>									
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>none</i>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <i>none</i>			21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>5/12</i> 19 <i>65</i> to <i>6/9/65</i> 19 <i>65</i> ; that (I) (we) last saw the deceased alive on <i>6/9</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Wm E Schwartz</i> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>6/9/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>W. E. SCHWARTZ</i> M.D.					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>6-12-65</i>		24C. NAME of CEMETERY or CREMATORY <i>HOLY REDEEMER</i>			24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 14 1965</i>		25B. NAME OF REGISTRAR <i>R. E. F. F. F.</i>			25C. FUNERAL DIRECTOR <i>ULLRICH FUNERAL HOME</i>			ADDRESS <i>BALTO. MD.</i>	



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.1. NAME OF DECEASED
(Type or Print)

CLAUDE S. WRIGHT

2. DATE AND HOUR PRONOUNCED DEAD

June 12, 1965

4:03 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4253 Shamrock Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

SEPT 29-1909

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

BUS DRIVER

10B. KIND OF BUSINESS OR INDUSTRY

TRANSIT CO

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

ROBERT E. L. WRIGHT

14. MOTHER'S MAIDEN NAME

GRACE TAYLOR

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

213-159139

17. INFORMANT

ADDRESS

MRS ANNA WRIGHT 4253 SHAMROCK

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 12, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

6/15/65

23C. NAME OF CEMETERY or CREMATORY

GARDENS OF FAITH

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE CO. MD

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 14 1965

R. E. Adams, M.D.

ULLRICH FUNERAL HOME 4210 BELAIR

WALLACE & GORGE
CO. CONTACT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

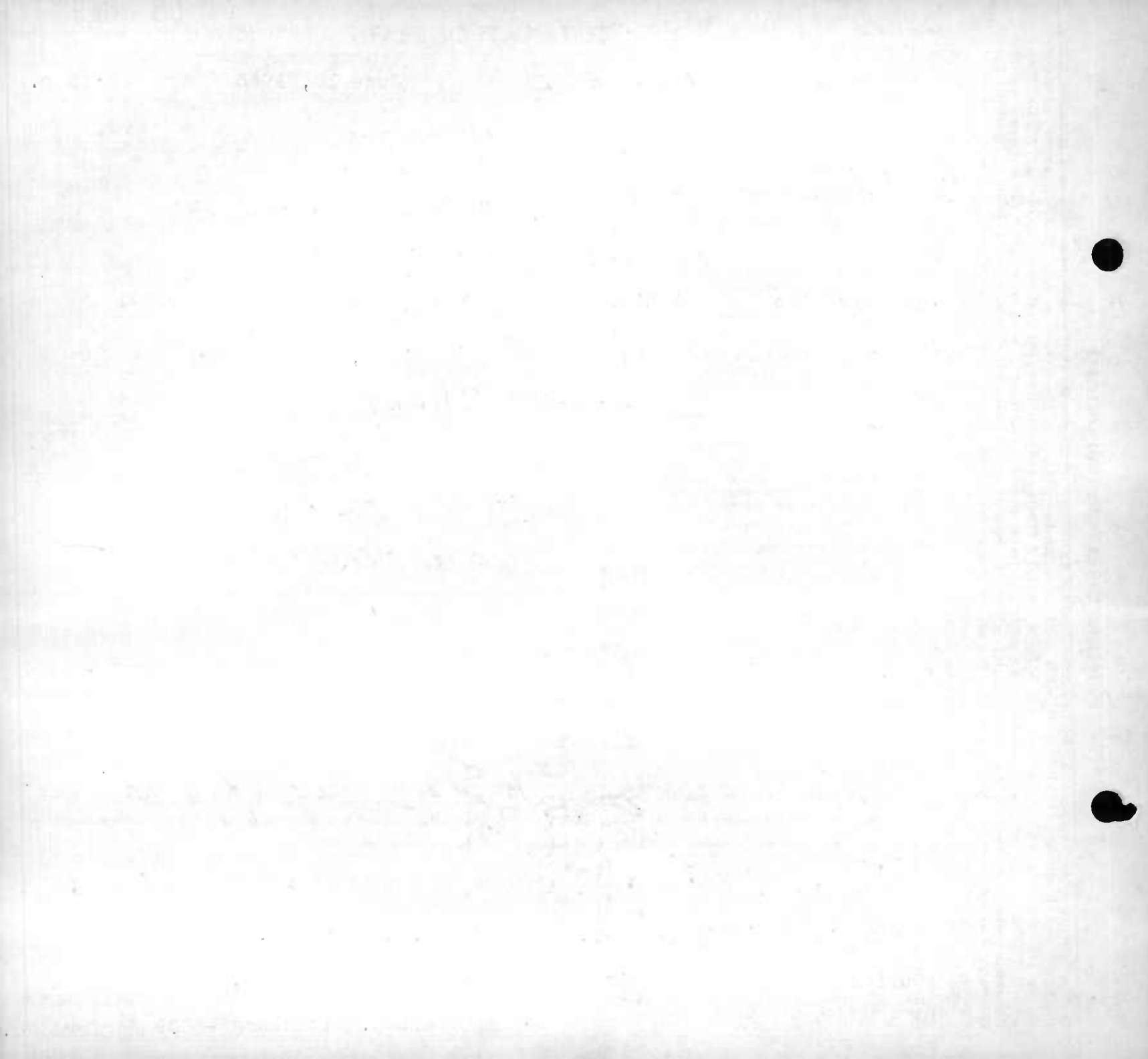
BIRTH NO. 65 6192				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6192	
M.E. CASE NO.				1. NAME OF DECEASED (Type at Print) MARY E. HARVEY			
2. DATE AND HOUR OF DEATH June 7, 1965				M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE CORRECTED 7-23-65 FULL NAME OF HOSPITAL OR INSTITUTION 3239 Elmora Avenue				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 8-01			
5. SEX Female				6. RACE Cauc.			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed				8. DATE OF BIRTH 1893 May 29, 1893			
9. AGE (In years lost birthday) -86- 72				10. If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James Kelly				14. MOTHER'S MAIDEN NAME Margaret Hawkins			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Margaret Jenkins 3239 Elmora Ave. 13				ADDRESS			
18. 4200 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ostehenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Oste. Arthritis II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Undernourished				INTERVAL BETWEEN ONSET AND DEATH 1958 ?			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from March 1958 to June 7 1965 , that (I) (last) saw the deceased alive on June 7 1965 and that (in my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE Louis F. Klimes M.D.				23B. DATE SIGNED June 9, 1965			
23C. PHYSICIAN'S NAME (Type) Louis F. Klimes				23D. ADDRESS 2623 E7 Monument St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 6-10-65			
24C. NAME of CEMETERY or CREMATORY Holy Redeemer				24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
25C. FUNERAL DIRECTOR Ullrich Funeral Home Balto., Md.				ADDRESS			

Marriage Record from Balto. City
7-23-65 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6193		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6193	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HERPEL BESSIE B		2. DATE AND HOUR OF DEATH June 12, 1965 5:15 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NORTH CHARLES GEN. Hosp. 2724 N. Chas. St. #18		A. STATE MARYLAND B. COUNTY 8-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2016 E LANVALE ST			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-2-1892	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembly line		10B. KIND OF BUSINESS OR INDUSTRY Distillery		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Blight, Howard M		14. MOTHER'S MAIDEN NAME Hiltz, CORA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-6126		17. INFORMANT CHART	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, esthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Congestive heart failure. DUE TO (B) Arteriosclerotic Cardio- DUE TO (C) vascular disease.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 30 1965 to June 12 1965 , that (I) (we) lost saw the deceased alive on June 12 at 5:15 PM 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles M. Allington		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/12/65	
23C. PHYSICIAN'S NAME (Type) MARION FRIEDMAN		23D. ADDRESS 2724 N. Charles St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/16/65		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Robert C. Altenburg	
25D. ADDRESS -6009 Harford Rd.					



43-60-18 AM

65 6194

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

65-6194

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Charles C. Zwick

2. DATE AND HOUR OF DEATH

6-8-65

9:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3529 East Fayette Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

5-29-92

9. AGE (In years
last birthday)

73

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Bricklayer

10B. KIND OF BUSINESS OR INDUSTRY

Building

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Christian Zwick

14. MOTHER'S MAIDEN NAME

Annie Griffon

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

212-09-1285

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue #21

18.

443X I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Cerebral Vascular Accident
DUE TOINTERVAL BETWEEN
ONSET AND DEATH

1 Month

(B) Hypertensive Arteriosclerotic
DUE TO Cardio Vascular Disease

10 Years

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-15 19 65 to 6-8- 19 65,
that (I) (we) last saw the deceased alive on 6-8- 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6-8-65

23C. PHYSICIAN'S
NAME (Type)

Dr. Howard Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6-12-65

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

Balto. Co., Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 14 1965

25B. NAME OF REGISTRAR

Robert E. Farkner

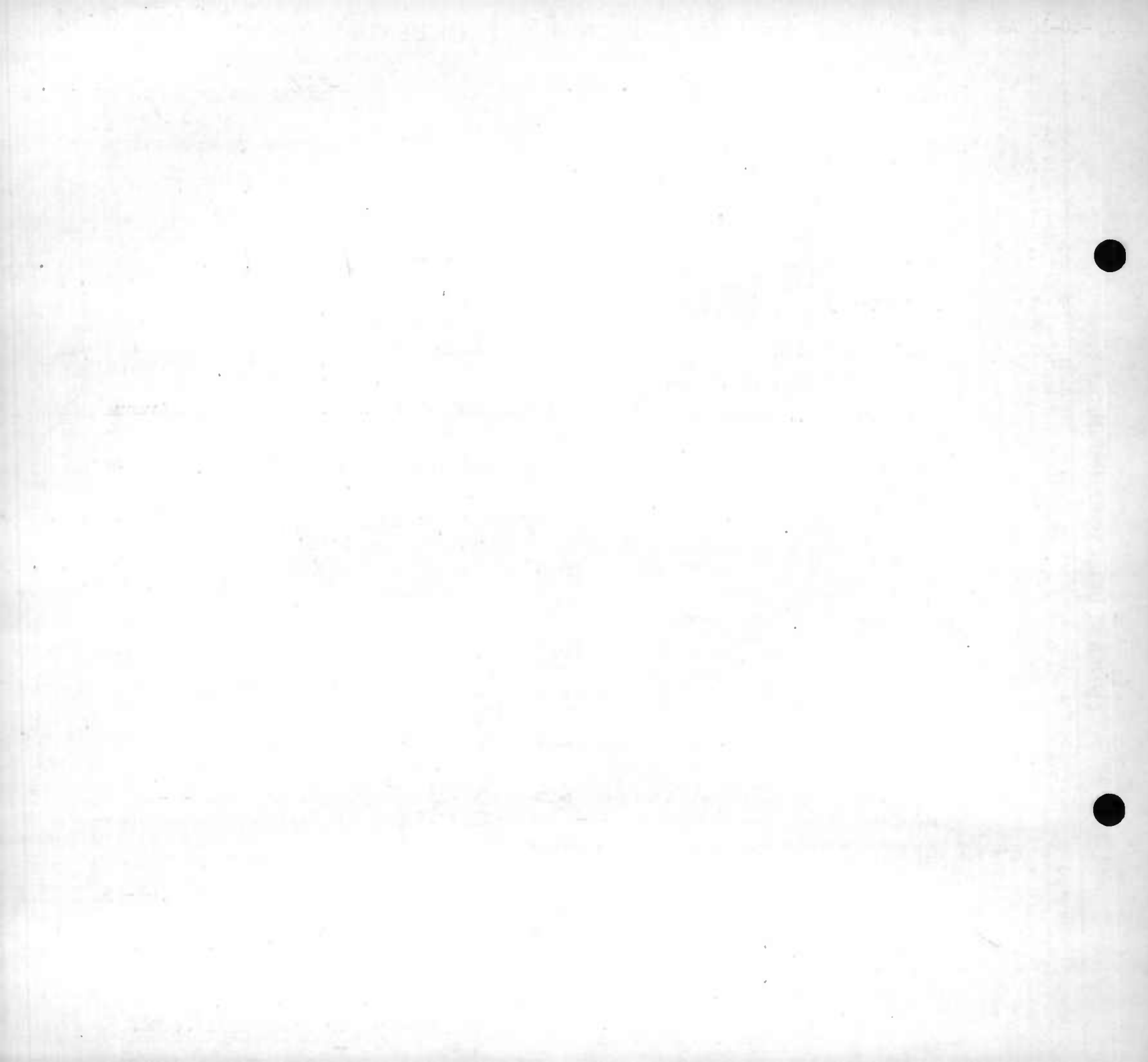
25C. FUNERAL DIRECTOR

Ullrich Funeral Home Balto., Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

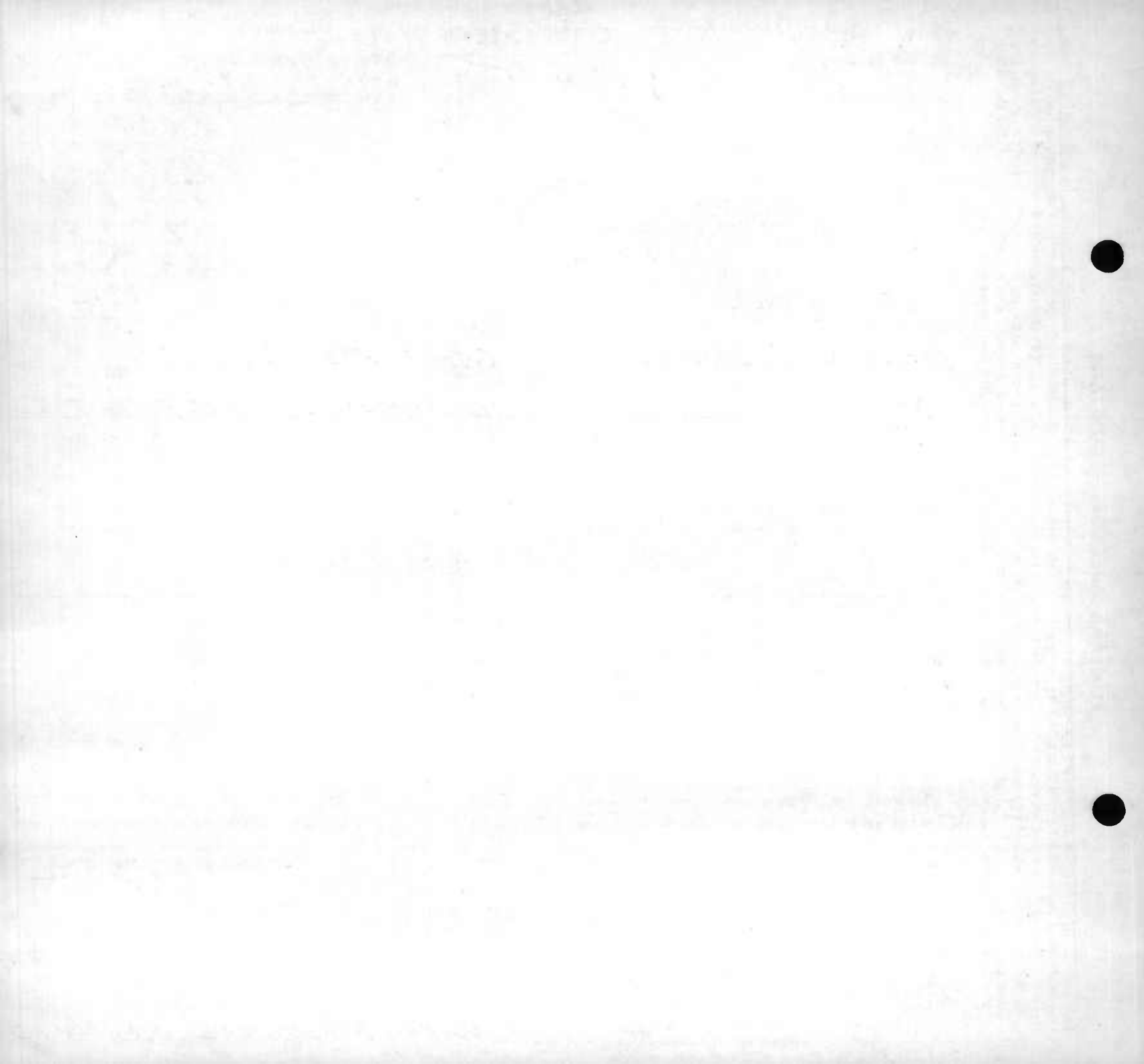
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 6195</u>	
BIRTH NO. <u>65 6195</u>		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>6-12-65 1145 p.m.</u>	
1. NAME OF DECEASED (Type or Print) <u>MENDEZ ; VINCENT</u>		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 UNIVERSITY HOSPITAL</u>		A. STATE <u>MD.</u> B. COUNTY <u>Balt</u>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE #19 53-00</u>	
		D. STREET ADDRESS (If rural, give location) <u>1317 FORREST RD.</u>	
5. SEX <u>M</u>	6. RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>4/5/05</u>
		9. AGE (In years last birthday) <u>60</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEEL WORKER</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MEXICO</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>MARTIN MENDEZ</u>	
14. MOTHER'S MAIDEN NAME <u>GUADALUPE JUAREZ</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>HENRY MENDEZ - 1777 FORREST RD</u>	
18. <u>45-1X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
ANTECEDENT CAUSES		(A) DUE TO <u>CARDIAC ARREST</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <u>DISSECTING THORACIC ANEURYSM</u>	
		(C) <u>ATHEROSCLEROSIS</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION			
19A. DATE OF OPERATION <u>6/11/65</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>DISSECTING THORACIC ANEURYSM</u>	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-11</u> 19 <u>65</u> to <u>6-12</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>6-12</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Roman Herman</u>		23B. DATE SIGNED <u>6/12/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>ROMAN HERMAN</u>		23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>6/16/65</u>	24C. NAME of CEMETERY or CREMATORY <u>GARDENS OF FAITH</u>	24D. LOCATION (City, town, or county) (State) <u>BALTIMORE CO. MD</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 14 1965</u>	25B. NAME OF REGISTRAR <u>Robert E. Farley</u>	25C. FUNERAL DIRECTOR ADDRESS <u>ULURICH FUNERAL HOME DUNDALK MD</u>	



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

John Carlson

2. DATE AND HOUR PRONOUNCED DEAD

June 12, 1965

4:20 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6704 Bessemer Avenue

5. SEX

XX Male White

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

July 2, 1896

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Steel

11. BIRTHPLACE (State or foreign country)

Finland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Matti Carlson

14. MOTHER'S MAIDEN NAME

Helvi Nauriskoski

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

194-05-2444

17. INFORMANT

ADDRESS

Mrs. Ida Carlson 6704 Bessemer Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive and arteriosclerotic
DUE TO cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 12, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/15.65

23C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

(City, town, or county)

Colgate, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 14 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Ullrich Funeral Home Dundalk, Md.

ADDRESS

VALLEY MORGE

NOV 2 1911

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

FLORYAN TRZCINSKI

2. DATE AND HOUR PRONOUNCED DEAD

June 9, 1965

7:40 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3511 Dudley Avenue

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

1/22/1916

9. AGE (In years
last birthday)
49If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Welder

10B. KIND OF BUSINESS OR INDUSTRY

Beth. Steel

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Stanislaus Trzcinski

14. MOTHER'S MAIDEN NAME

Veronica Fatajczak

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W.W.2 - Army

16. SOCIAL
SECURITY NO.

212-05-8053

17. INFORMANT

ADDRESS

Dorothy Trzeciak Trzcinski, wife, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?
Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-10-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/14/65

23C. NAME of CEMETERY or CREMATORY

St. Stanislaus Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 14 1965

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.
3331 Brehms Lane

ADDRESS

WALTER FOREGE

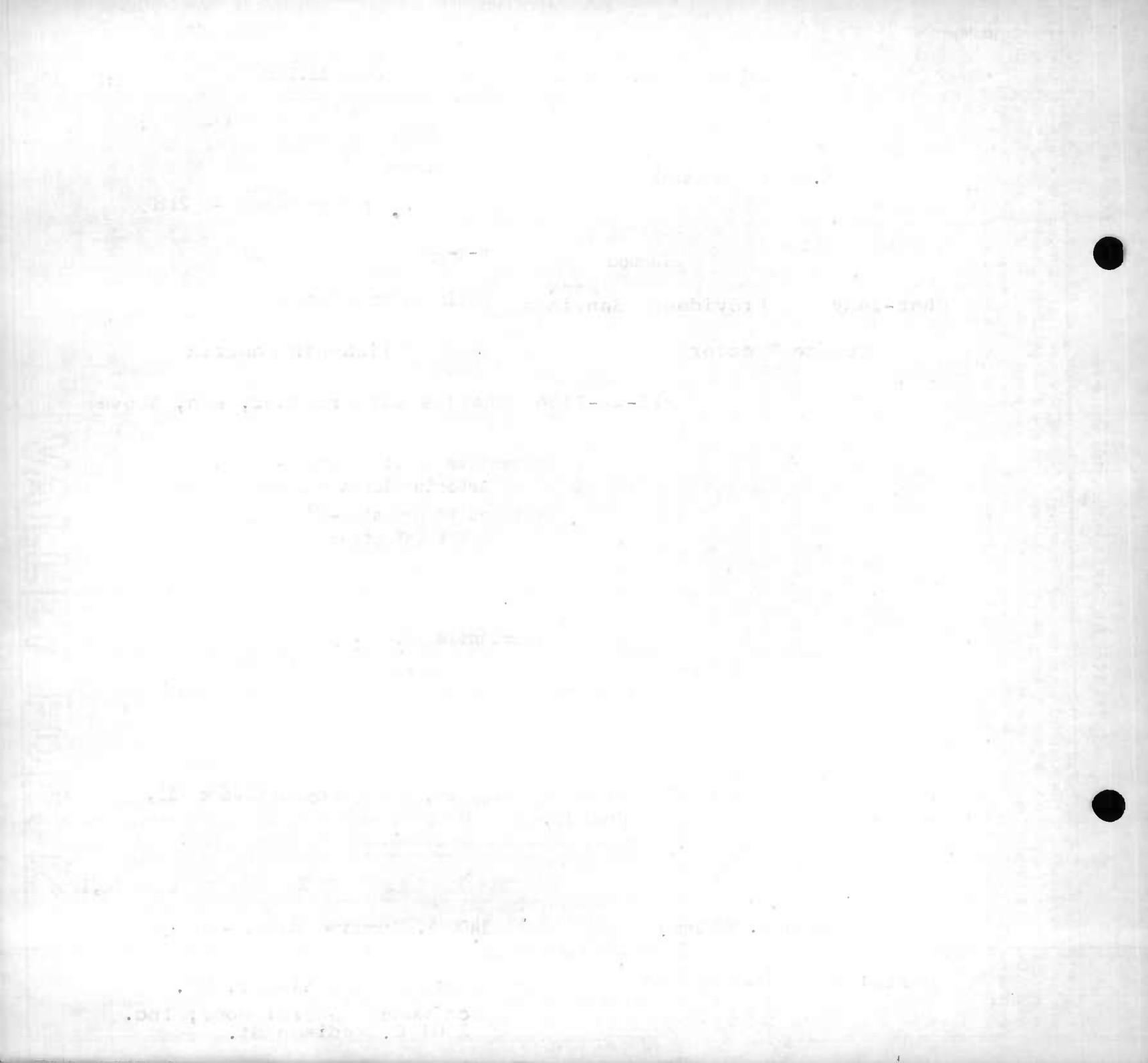
1/23/78
Baltimore, Md.
Technical Data Clerk
The U.S. Army
Fort Monmouth, New Jersey

Bureau of the
St. Lawrence County
Baltimore, Md.
Baltimore, Md.
Baltimore, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

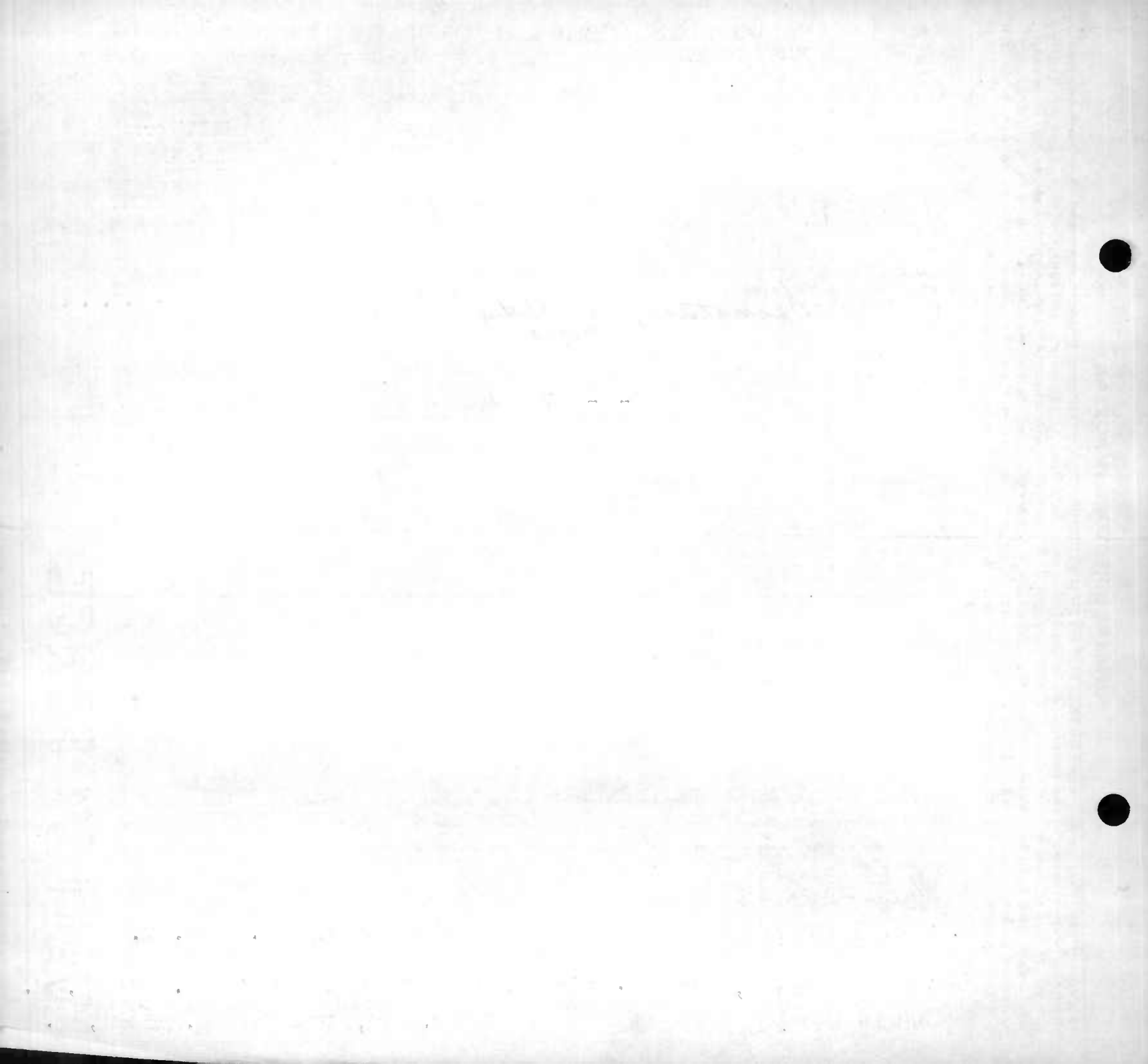
BIRTH NO.		65 6198		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		65 6198		
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)				UTTENREITHER, ETHEL BLANCHE		
2. DATE AND HOUR OF DEATH				June 11, 1965				2:05 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				A. STATE Maryland		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Baltimore		
St. Joseph Hospital				D. STREET ADDRESS (If rural, give location)				2822 E. Monument Street - 21205		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 9-2-95	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Char-lady			Providence Savings Bank			Falls Church, Virginia				
13. FATHER'S NAME Eugene Proctor				14. MOTHER'S MAIDEN NAME Elizabeth Maderia						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 215-24-7156		17. INFORMANT Charles Uttenreither, son, above				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH		
(A) Congestive Heart Failure - 2° to Arteriosclerotic heart disease										
(B) Obstructive uropathy - 2° to Urinary tract infection										
(C)										
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Procedentia						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) none		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?						
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>								
22. I certify that (I) (this hospital) attended the deceased from May 28, 1965 to June 11, 1965, that (I) (we) lost saw the deceased alive on June 11, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Rostom D. Rivera				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED June 11, 1965		
23C. PHYSICIAN'S NAME (Type) Rostom D. Rivera				23D. ADDRESS M.D. 1400 N. Caroline Street - 21213						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/14/65		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 2601 E. Madison St.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6199				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6199	
M.E. CASE NO. NADIA HOWARD				2. DATE AND HOUR OF DEATH 6-11-65 12:05 P.M.			
1. NAME OF DECEASED (Type or Print) Nadia Howard				3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Dundalk 53-00				D. STREET ADDRESS (If rural, give location) 2913 Yorkway 21222			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Wid	8. DATE OF BIRTH 9-12-08	9. AGE (In years lost birthday) 56	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Refused - Seamstress, G & G. City			10B. KIND OF BUSINESS OR INDUSTRY Russia		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Gursky			14. MOTHER'S MAIDEN NAME Tanya Lookina				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217-26-0697		17. INFORMANT daughter-in-law - Alexander Howard		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ostemia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7 Am 6-11 19 65 to 12:05 PM 6-11 19 65, that (I) (we) last saw the deceased alive on 6-11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Miriam R. Cohen				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-11-65	
23C. PHYSICIAN'S NAME (Type) Miriam Cohen				23D. ADDRESS M.D. Union Memorial Hosp. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 15, 1965		24C. NAME OF CEMETERY or CREMATORY St. Andrew Russian Orthodox		24D. LOCATION (City, town, or county) (State) German Hill Rd. Dundalk, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS JOHN J. DUDA, 7922 Wise Ave. Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

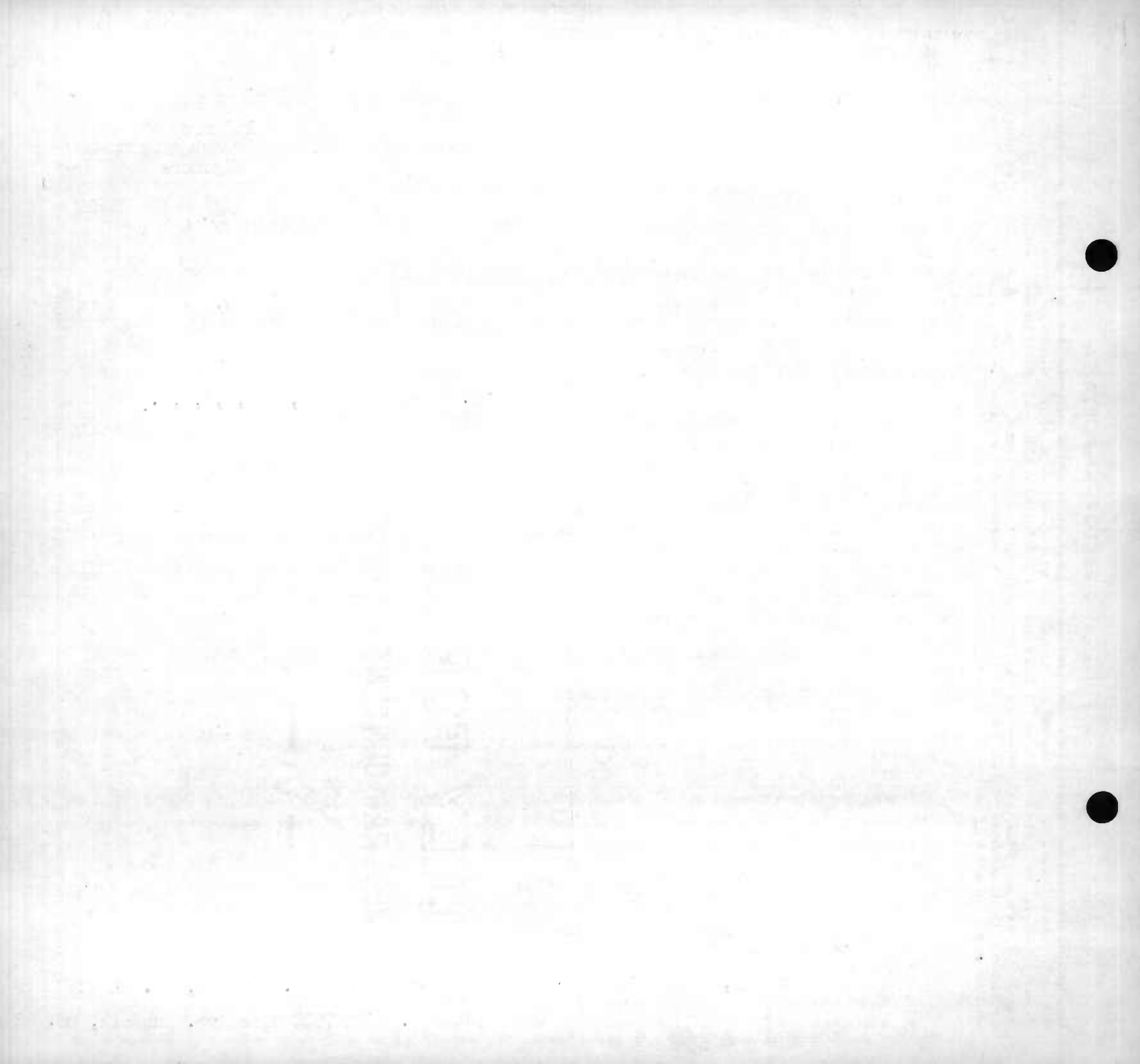
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 6200		CERTIFICATE OF DEATH		Registered No. 65 6200	
1. NAME OF DECEASED (Type or Print) MALINOWSKI, Mary				2. DATE AND HOUR OF DEATH June 10, 1965 2:55 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 1-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 702 - S. Ellwood Avenue					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WID.	8. DATE OF BIRTH 5-20-1888	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Poland -		12. CITIZEN OF WHAT COUNTRY? -			
13. FATHER'S NAME JOHN ZULEWSKI				14. MOTHER'S MAIDEN NAME ANGELO LUBOWSKI					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or known) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT PT. & LAURA M. CEEH (daughter) S/A		ADDRESS			
18. I 155.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) METASTATIC CARCINOMA of GALLBLADDER ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute pulmonary edema Obstructive jaundice				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 6/7/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstructive jaundice		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5/22 19 65 to 6/10 19 65 , that (I) (we) last saw the deceased alive on 6/10 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Francesco Sandiford				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/10/65			
23C. PHYSICIAN'S NAME (Type) Francesco Sandiford		23D. ADDRESS University Hospital, Balto. Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 14, 1965		24C. NAME of CEMETERY or CREMATORY St. Stanislaus		24D. LOCATION (City, town, or county) (State) Dundalk, Md. 21224			
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR JOHN J. DUDA		ADDRESS 2829 Hudson St. Balto. Md.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

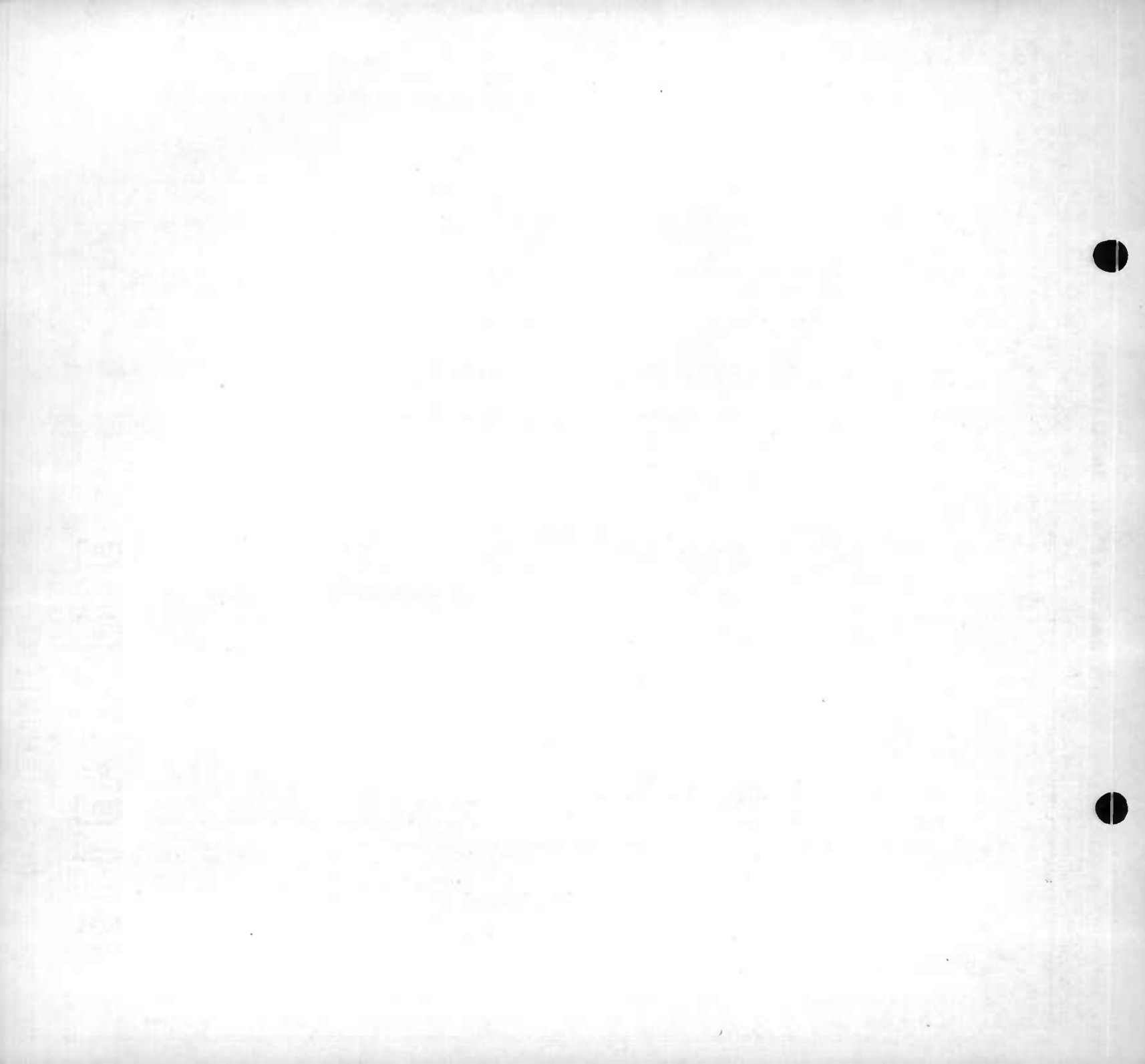
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 6507604		65 6201		65 6201	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Kimberly Ann, Munski				2. DATE AND HOUR OF DEATH June 9, 1965 9:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital of Baltimore		(If not in hospital or institution, give street address or location)		A. STATE Maryland B. COUNTY Baltimore	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Edgemere 5300	
				D. STREET ADDRESS (If rural, give location) 3011 Delmar Ave 21219	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married		8. DATE OF BIRTH 4-2-65	9. AGE (In years last birthday) 27
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Kenneth Munski				12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 0 0				14. MOTHER'S MAIDEN NAME Judy Greenwald	
16. SOCIAL SECURITY NO. 0				17. INFORMANT Mr. Kenneth Munski, # 4, a, b, c, d.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 351X1			(A) DUE TO Severe Brain Damage - Congenital		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 7 1965 to June 9 1965, that (I) (we) lost saw the deceased alive on June 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edward J. Koenigsberg				23B. DATE SIGNED June 9, 1965	
23C. PHYSICIAN'S NAME (Type) Edward J. Koenigsberg				23D. ADDRESS Sinai Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 11, 1965		24C. NAME OF CEMETERY or CREMATORY Christ Lutheran	
				24D. LOCATION (City, town, or county) (State) German Hill Rd. Dundalk, Md. 21222	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR JOHN J. DUDA 7922 Wise Ave. Dundalk, Md. 22	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

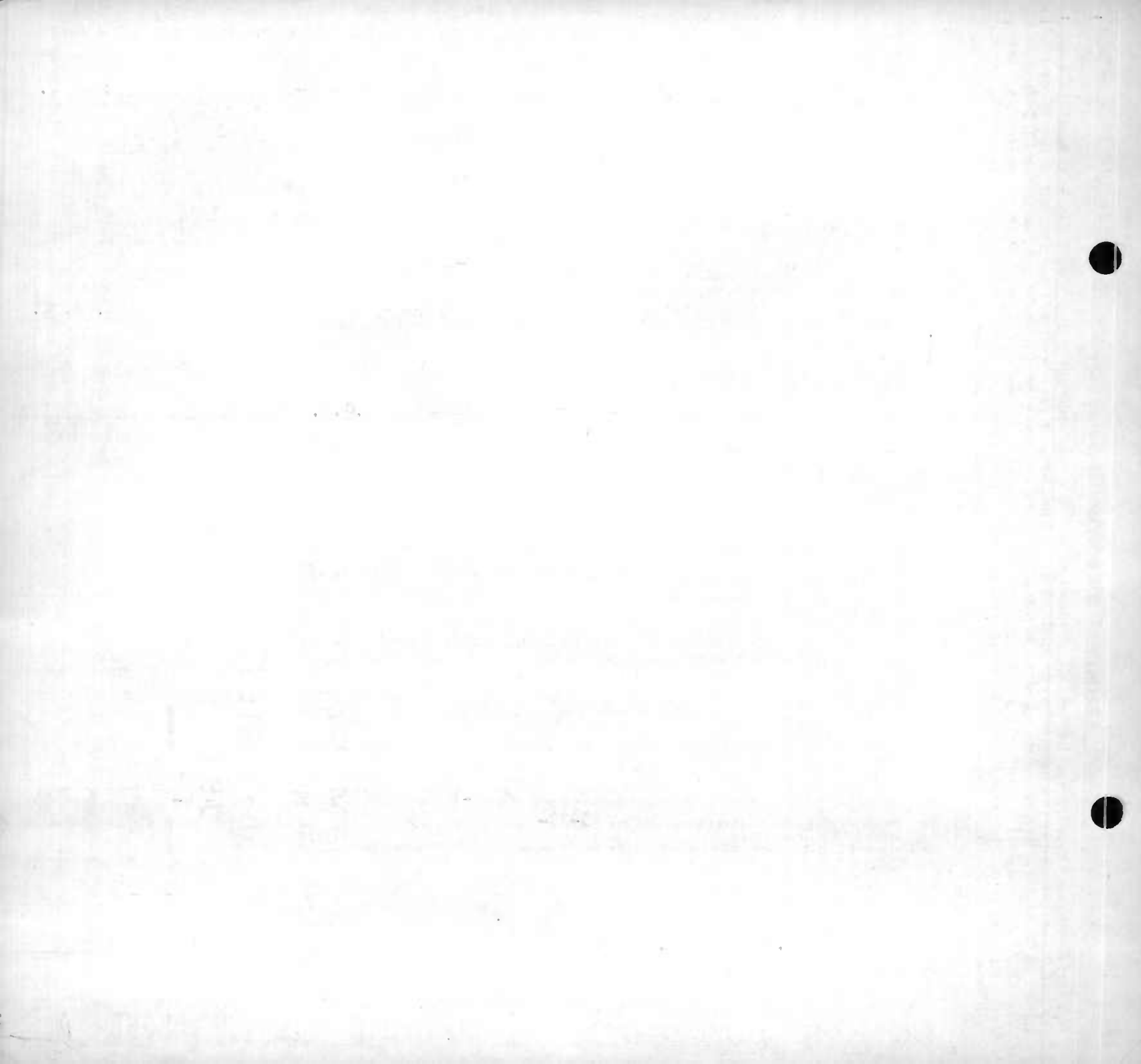
BIRTH NO. 65 6202		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6202	
M.E. CASE NO.		CERTIFICATE OF DEATH		FUNK	
1. NAME OF DECEASED (Type or Print) Elizabeth Furuk		2. DATE AND HOUR OF DEATH 6-7-65 11230 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Windsor Rest Home		A. STATE B. COUNTY 15-47			
5. SEX Female		6. RACE Wh.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 1/2/1888	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday) 77	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO Coronary Thrombosis		1 day	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Cardiovascular Disease?			
II		(C) Arteriosclerosis		?	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 15 1965 to June 7 1965.		that (I) (we) last saw the deceased alive on 6-5-65 1965 and that in (my) (our) opinion death occurred on the date		and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/7-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 403 Melrose Ave		M.D.	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE JUN 14 1965		24C. NAME OF CEMETERY OR CREMATORY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

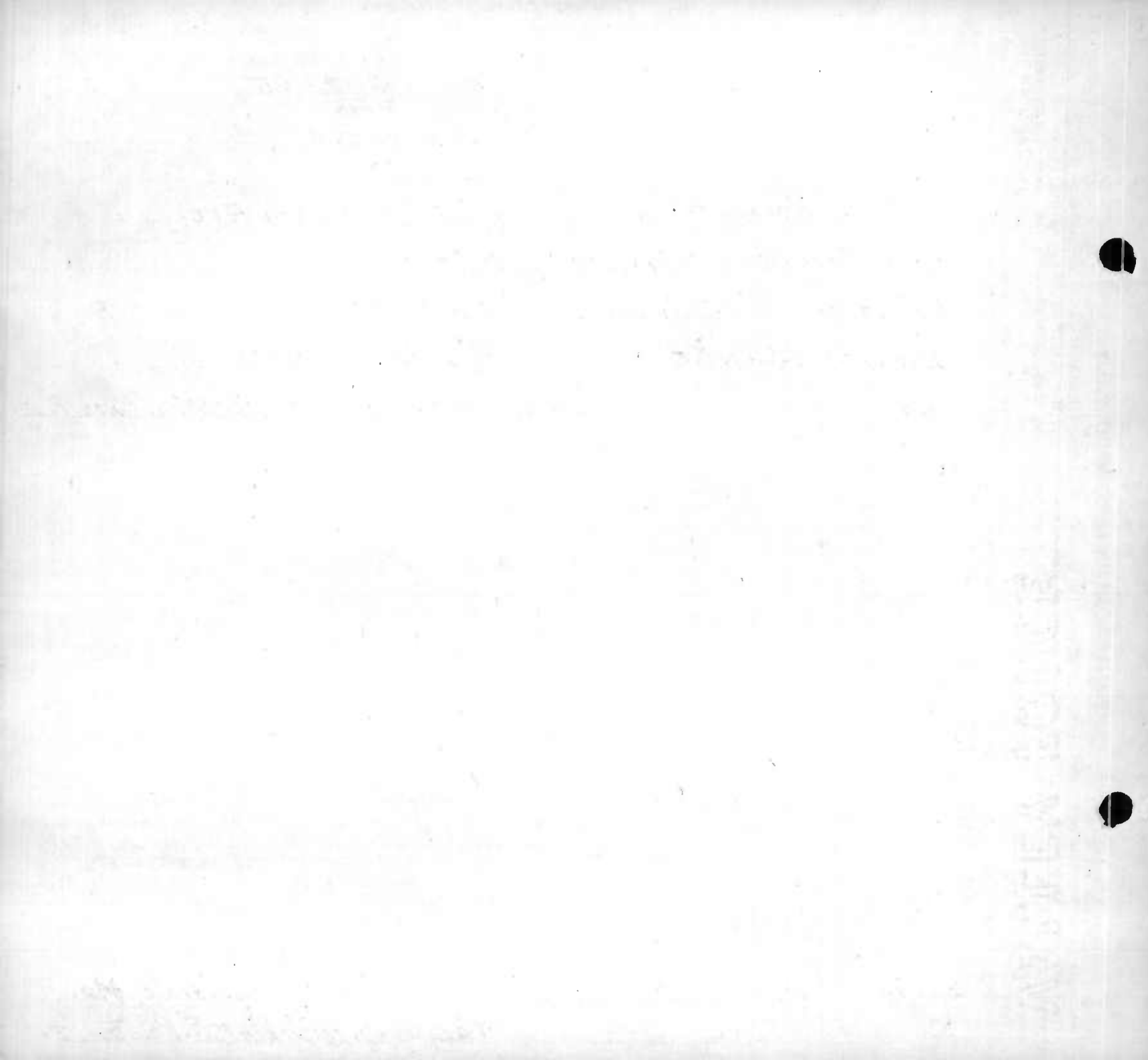
BIRTH NO.		65 6203		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6203	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print)				5-29-65 3:00 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				Maryland 26-12			
5. SEX				6. DATE OF BIRTH			
Male White				7-17-86			
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				9. AGE (In years last birthday)			
Widowed				78			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
				Delaware			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
				U. S. A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				216-18-5995			
17. INFORMANT				ADDRESS			
RECORDS: B.C.H. 4940 Eastern Avenue #21224							
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) Septicemia			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				DUE TO			
ANTECEDENT CAUSES				(B) Chronic Urinary Tract Infection,			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO Benign Prostatic Hypertrophy			
(C)							
II				Arteriosclerotic Cardio Vascular Disease			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
D				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8-14 19 57 to 5-29- 19 65, that (I) (we) lost saw the deceased alive on 5-29- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		5-29-65	
Dr. Howard K. Rathbun				4940 Eastern Avenue #21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
		JUN 14 1965		ANATOMY BOARD OF MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 14 1965		Robert E. Farley, M.D.		UNIVERSITY MEDICAL SCHOOL		MORTUARY SERVICE - BCHD	



FUNERAL DIRECTOR: IMPORTANT

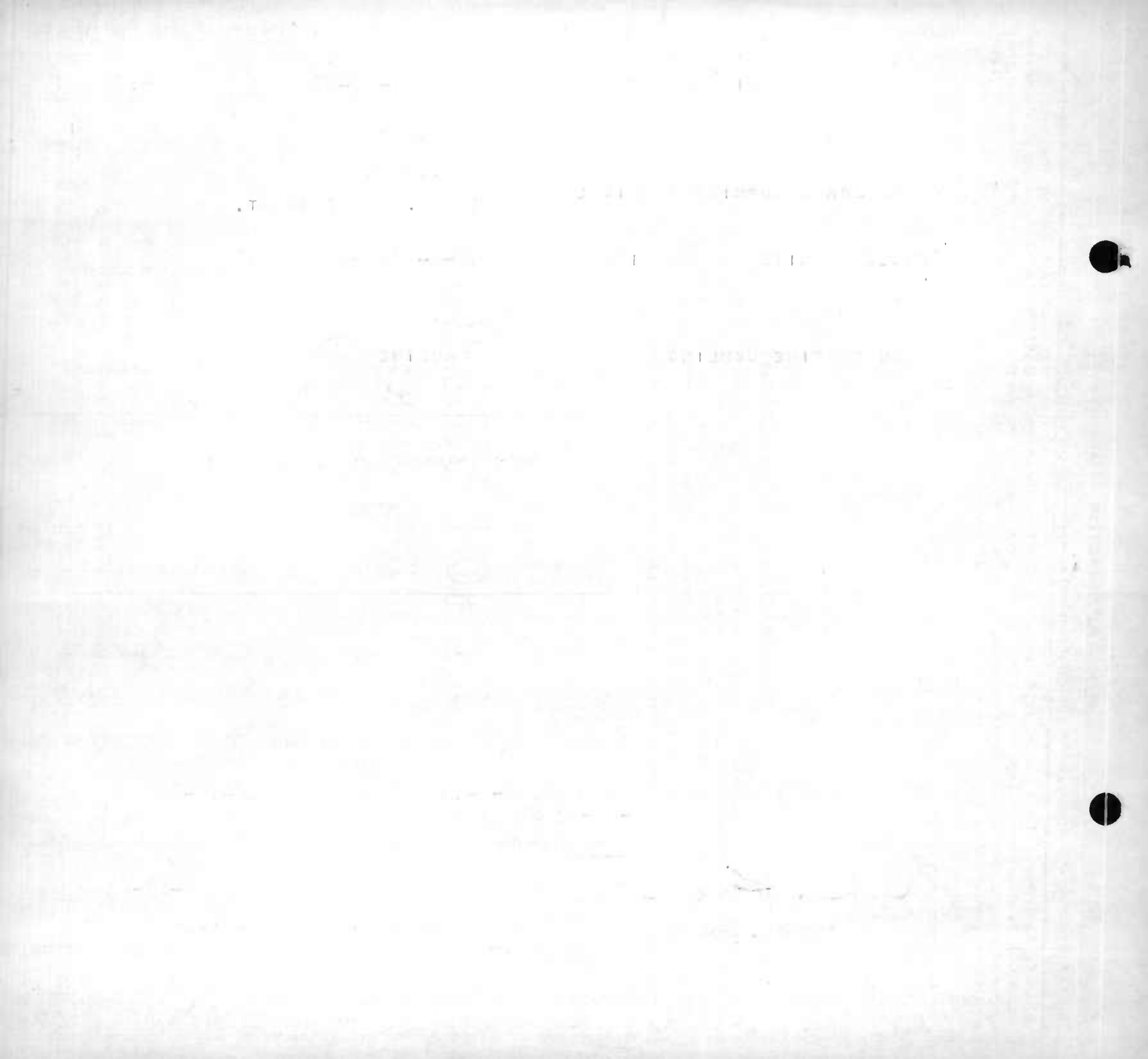
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6204		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6204	
M.E. CASE NO.		1. NAME OF DECEASED Lewis Banks		2. DATE AND HOUR OF DEATH 6-9-65 12:05 P. M.	
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-04	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
2913 Parkwood Ave.		2913 Parkwood Ave.		D. STREET ADDRESS (If rural, give location)	
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1-?-1896	9. AGE (In years lost birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY Shipyard		11. BIRTHPLACE (State or foreign country) Warwick Co., Va.	
13. FATHER'S NAME Daniel Banks		14. MOTHER'S MAIDEN NAME Pinkie Robinson		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-12-7339		17. INFORMANT Mrs. Martha Contee	
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Cerebral Hemorrhage DUE TO 1945 (B) Hypertensive Cardio- DUE TO 27 (C) Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-10-63 19 to 6-9-65 19, that (I) (we) last saw the deceased alive on 6-9-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. Franklin Phillips		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/1	
23C. PHYSICIAN'S NAME (Type) G. Franklin Phillips		M.D. 558 No 9th St Baltimore Md		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-12-65		24C. NAME OF CEMETERY OR CREMATORY McCalvary Cemetery	
24D. LOCATION Anne Arundel Co. Md.		24E. NAME OF REGISTRAR Robert E. Farley		24F. FUNERAL DIRECTOR Randolph J. Collick	
24G. DATE REC'D BY HEALTH DEPT. JUN 14 1965		24H. NAME OF REGISTRAR Robert E. Farley		24I. FUNERAL DIRECTOR Randolph J. Collick	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6206				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6206	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				JOHN FRANCIS HENRY		6-11-65	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE		B. COUNTY	
(If not in hospital or institution, give street address or location)				MARYLAND		27-34	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
WIDOWED				D. STREET ADDRESS (If rural, give location)		3823 WHITE AVE.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
M	W	WIDOWED	10-6-1889	75			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
WATCHMAN			CHEMICAL Co.		MARYLAND		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
UNKNOWN				KATHLEEN HORAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No						Mr. Charles F. Henry - 3823 White Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Most Probable Pulmonary in Origin.			
II				ASCENDING Atrial Fibrillation.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
1-10-6-9-65		Made Bypass		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (this hospital) attended the deceased from 6-3-1965 to 6-11-1965, that (we) last saw the deceased alive on 6-11-1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Robert L. Syle				6-11-65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		6-15-65		HOLY REDEEMER CEM.		BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 14 1965		Robert E. Fulk		Hartley Miller - Mountford & Jefferson			

My dear Sir

With regards to the

Account, I am

Very truly

Yours

W

W

W

W

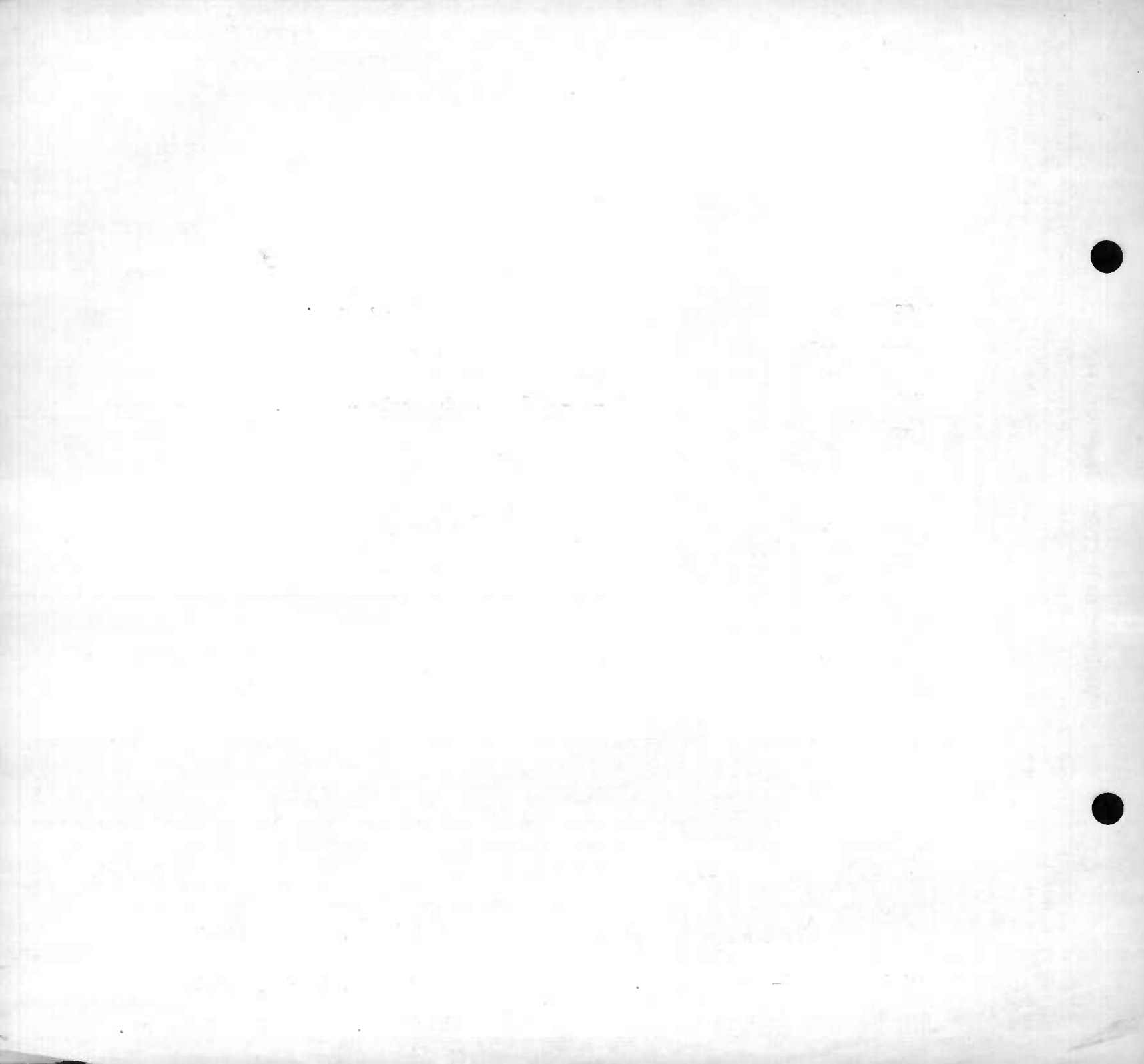
Robert L. Hoff

X

W

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6207		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 6207	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>James C. Poole</i>			2. DATE AND HOUR OF DEATH <i>June 11, 1965 - 930 P. M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>19-01</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>425 N. Stricker St</i>		
5. SEX <i>male</i>	6. RACE <i>negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>04-16-02</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Longshoreman</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Old Corney, S. C.</i>	
13. FATHER'S NAME <i>George Poole</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>215-05-3331</i>		17. INFORMANT <i>Addie Poole - 425 N. Stricker Street</i>
18. <i>444X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <i>Anemia</i> DUE TO (B) <i>Hypertension</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/12/1965</i> to <i>6/11/1965</i> , that (I) (we) last saw the deceased alive on <i>6/11/1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Michael Freund</i>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/11/65</i>
23C. PHYSICIAN'S NAME (Type) <i>Michael Freund</i>			23D. ADDRESS <i>550 N. Broadway</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-15-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		(State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 14 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, JR.</i>		25C. FUNERAL DIRECTOR <i>Charles R. Law</i>	
ADDRESS <i>802 Madison Ave.</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 6208		CERTIFICATE OF DEATH		Registered No. 65 6208	
1. NAME OF DECEASED (Type or Print) <u>Johnson, Mary</u>				2. DATE AND HOUR OF DEATH <u>11 June 65, 12⁵⁰ P.M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Montebello State Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1901</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1700 W. Mulberry Street</u>					
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widow</u>		8. DATE OF BIRTH <u>5/10/1900</u>		9. AGE (In years last birthday) <u>65</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Flannery Burger</u>				14. MOTHER'S MAIDEN NAME <u>Martha Craft</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>27-09-3599</u>		17. INFORMANT <u>Evelyn Williams - Fernhill Ave</u>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>199.2.1</u>				CAUSE OF DEATH (A) <u>cardiac arrest</u> DUE TO (B) <u>bronchopneumonia</u> DUE TO (C) <u>carcinomatosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>9 June 1965</u> to <u>11 June 1965</u> , that (I) (we) last saw the deceased alive on <u>11 June 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Robert W. Ireland</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>11 June 65</u>		
23C. PHYSICIAN'S NAME (Type) <u>Robert W. Ireland</u> M.D.				23D. ADDRESS <u>Montebello State Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-16-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 14 1965</u>				25B. NAME OF REGISTRAR <u>R. P. A. E. Fairley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Charles R. Law, 802 Madison Ave.</u>			

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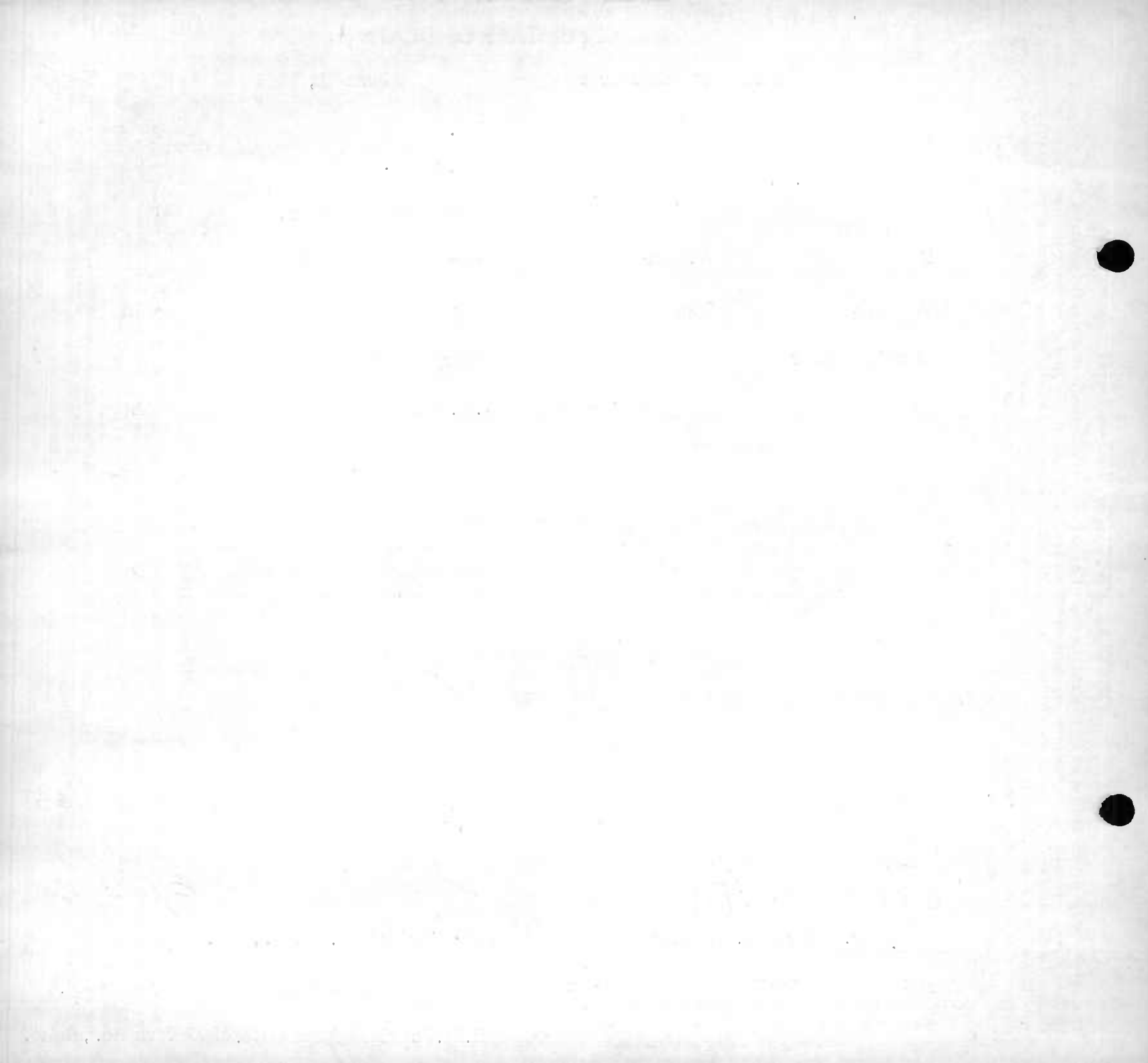
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
65 6209					Registered No. 65 6209														
BIRTH NO.					M.E. CASE NO.														
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH														
Laura May Schuchardt					June 11, 1965 3:40 P.M.														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)														
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould N. H.					A. STATE Md.														
					B. COUNTY Baltimore														
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 12					D. STREET ADDRESS (If rural, give location) 6503 Loch Hill Court														
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 9-9-1883	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.											
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA												
13. FATHER'S NAME Charles Bauer					14. MOTHER'S MAIDEN NAME Mary Denninger														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 217-07-5490		17. INFORMANT A. L. Burkman			ADDRESS Above											
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 yr					19. CAUSE OF DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 yr														
										19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
															20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?													
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)														
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?														
22. I certify that (I) (this hospital) attended the deceased from 1955 to June 11, 1965, that (I) (we) last saw the deceased alive on 6/11, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE Conrad L. Richter					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/12/65												
23C. PHYSICIAN'S NAME (Type) Dr. Conrad L. Richter					23D. ADDRESS 3128 Harford Rd. Balto., Md.														
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-14-65		24C. NAME of CEMETERY or CREMATORY Druid Ridge		24D. LOCATION (City, town, or county) (State) Pikesville Md.													
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4905 York Rd., Balto.															



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6210		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6210	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mr. Howard Gilbert Cooper		2. DATE AND HOUR OF DEATH 6/11/65 7:55 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Balto			
FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 5370	
D. STREET ADDRESS (If rural, give location) 6809 Bellong Ave		5. SEX M		6. RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (specify) Married		8. DATE OF BIRTH 8/18/91		9. AGE (in years lost birthday) 73	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Compt. Radiator Mfg.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Cooper		14. MOTHER'S MAIDEN NAME Serapta Whiting			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-4282		17. INFORMANT Elizabeth B. Cooper	
18. 163 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) CARCINOMA PT. Lung WITH METASTASES (B) DUE TO (C) Generalized Arteriosclerosis		ADDRESS Above INTERVAL BETWEEN ONSET AND DEATH MO - YRS	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 6/4/65 19 to 6/11 19 65, that (we) last saw the deceased alive on 6/11 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE William B. Long		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/11/65	
23C. PHYSICIAN'S NAME (Type) William B. Long		23D. ADDRESS Union Memorial Hospt.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-14-65		24C. NAME OF CEMETERY or CREMATORY West Middlesex	
24D. LOCATION Middlesex		24E. STATE Penna.			
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	
25D. ADDRESS 4905 York Rd.		25E. CITY, TOWN, OR COUNTY Balto. 12, Md.			

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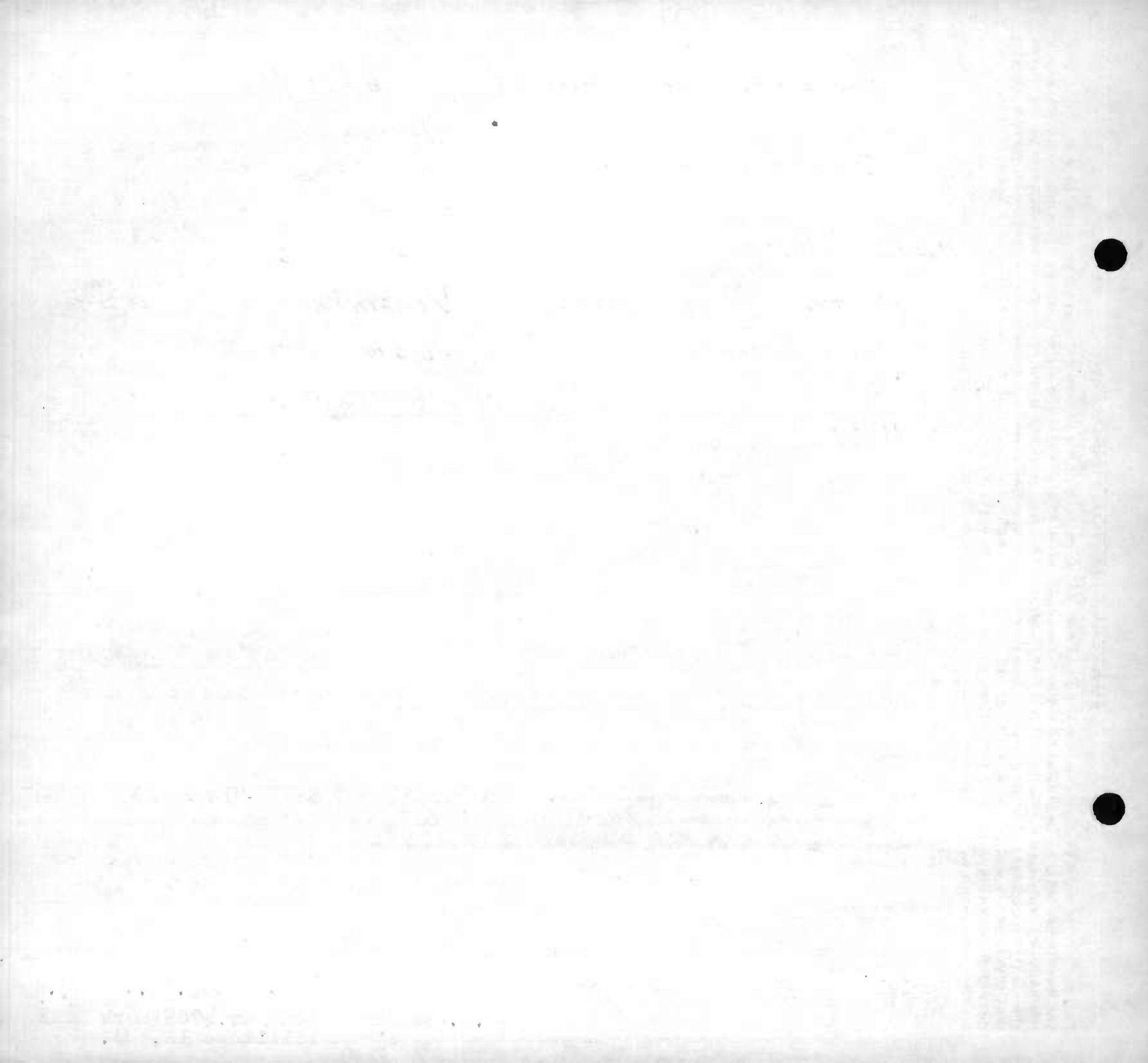
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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6211	
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MR. ELMER LEE SHERMAN	
2. DATE AND HOUR OF DEATH 6/13/65 11:25 A. M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-48		5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital			
6. DATE OF BIRTH 5-8-04		7. AGE (If years last birthday) 61		8. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 12	
9. STREET ADDRESS (If rural, give location) 605 Benninghaus Road		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Sherman	
14. MOTHER'S M maiden name Sadie Wilson		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-7754	
17. INFORMANT MRS. FRANCES H. SHERMAN		18. ADDRESS (SAME)			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cancer of lung		20. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
23. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 5 1965 to JUNE 13 1965 , that (I) (we) last saw the deceased alive on June 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Tai		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/13/65	
23C. PHYSICIAN'S NAME (Type) Tse-Wu Tai		23D. ADDRESS Bon Secours Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/16/1965		24C. NAME OF CEMETERY or CREMATORY Lorraine Park	
24D. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.			
25D. ADDRESS 4905 York Road Baltimore 12, Md.					



FUNERAL DIRECTOR: IMPORTANT

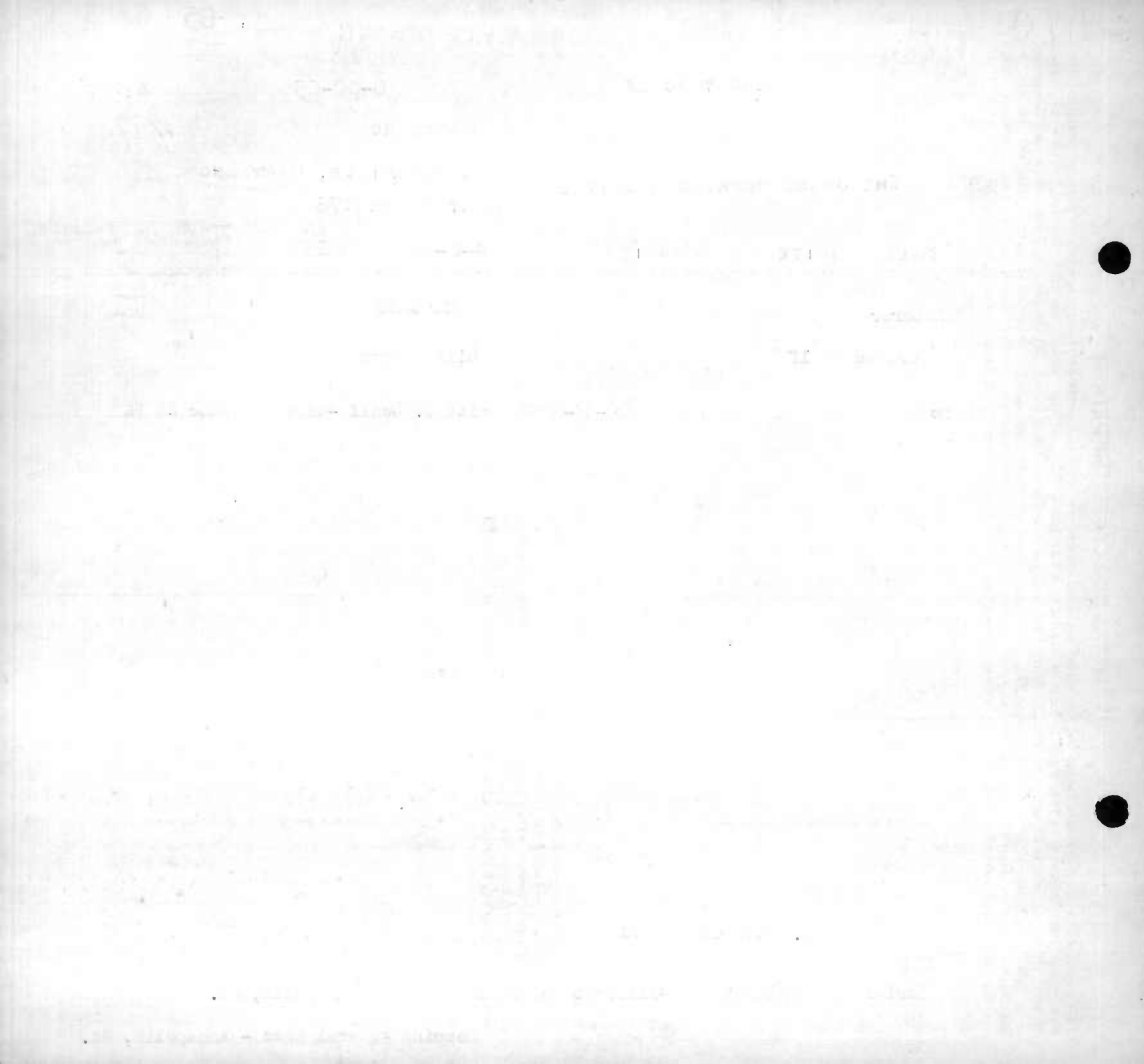
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 6212		CERTIFICATE OF DEATH		65 6212	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) OSCAR TURNER Smith, Jr.		2. DATE AND HOUR OF DEATH 6/14/65 12 ¹⁵ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND 12-01			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 UNION MEMORIAL Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) Ambassador Apartments			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	B. DATE OF BIRTH 11/1/99	9. AGE (In years lost birthday) 65	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chairman of Board Smith & Son, Co.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME OSCAR TURNER Smith		14. MOTHER'S MAIDEN NAME EDNA BRADSHAW			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.I		16. SOCIAL SECURITY NO. 212-07-6542		17. INFORMANT (Wife) SARA C. SMITH	
				ADDRESS SAME	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Myocardial infarction 6 hours (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 6 hours	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/13 19 65 to 6/14 19 65, that (I) lost saw the deceased alive on 6/13 19 65 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.					
23A. SIGNATURE William N. Bennett M.D.				23B. DATE SIGNED 6/14/65	
23C. PHYSICIAN'S NAME (Type) WILLIAM N. BENNETT M.D.				23D. ADDRESS UNION MEMORIAL Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/16/1965		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem. Grds. Timonium Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	

FUNERAL DIRECTOR: IMPORTANT

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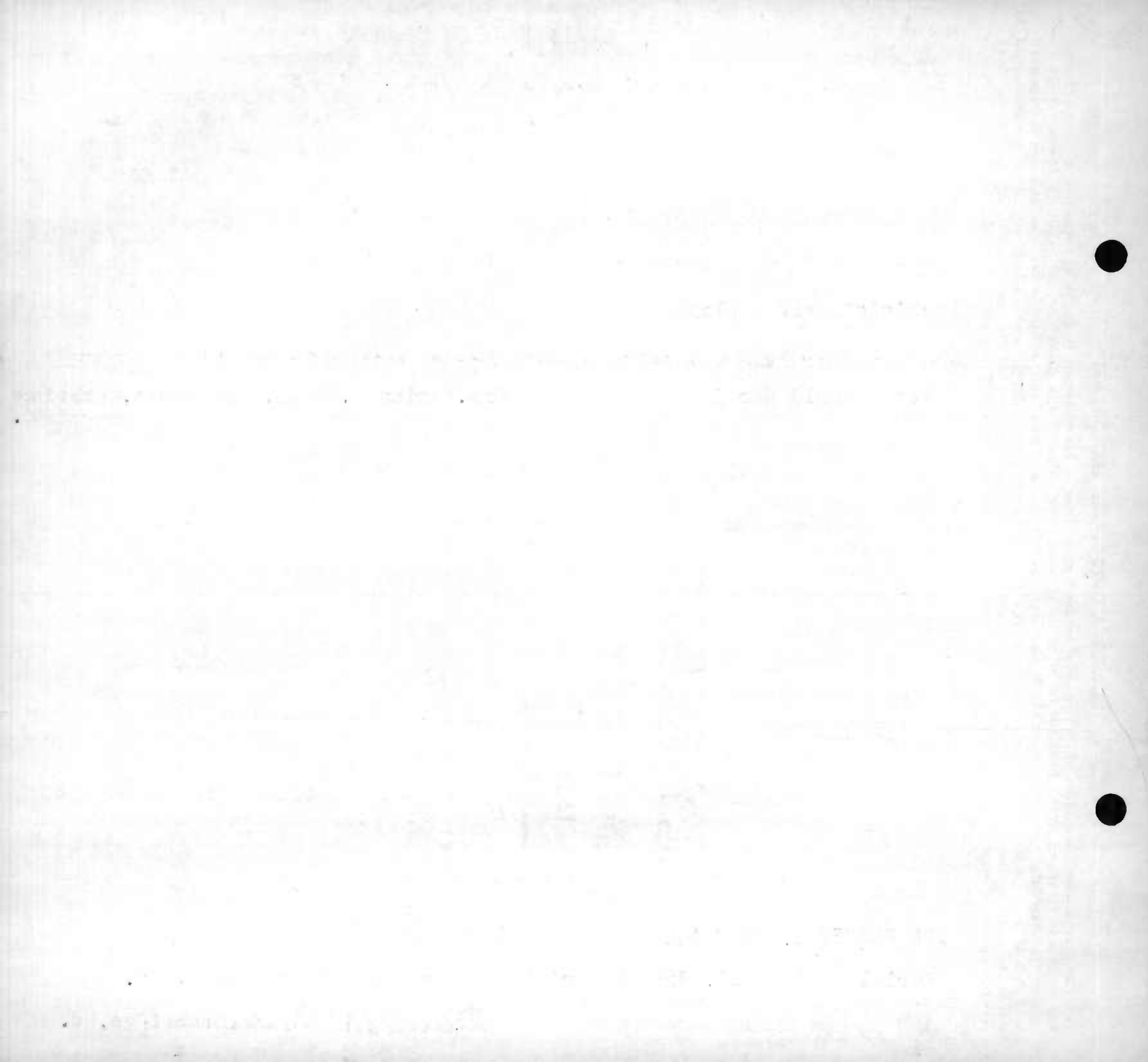
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6213	
BIRTH NO. 65 6213		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LARRY SCALF		2. DATE AND HOUR OF DEATH 6-10-65 4:30P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 99		C. CITY OR TOWN (If outside city limits, write RURAL and give township) CROWNSVILLE, MARYLAND 52-00	
FULL NAME OF HOSPITAL OR INSTITUTION RHE JOHNS HOPKINS HOSPITAL		D. STREET ADDRESS (If rural, give location) Rt 1 Box 176			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 4-6-42	9. AGE (In years lost birthday) 23	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Burdine Scalf		14. MOTHER'S MAIDEN NAME Bile Rogers		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-38-2050		17. INFORMANT ADDRESS Anita L. Scalf -wife same as #4	
18. 330X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Subarachnoid hemorrhage DUE TO (B) Cerebrovascular disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 days 23 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 25 1965 to June 10 1965 , that (I) (we) last saw the deceased alive on June 10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE Ronald Koons		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 10-65	
23C. PHYSICIAN'S NAME (Type) C. RONALD KOONS		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/14/65		24C. NAME OF CEMETERY or CREMATORY Hillcrest Memorial	
				24D. LOCATION (City, town, or county) (State) Annapolis, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR ADDRESS Hopping Funeral Home - Annapolis, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

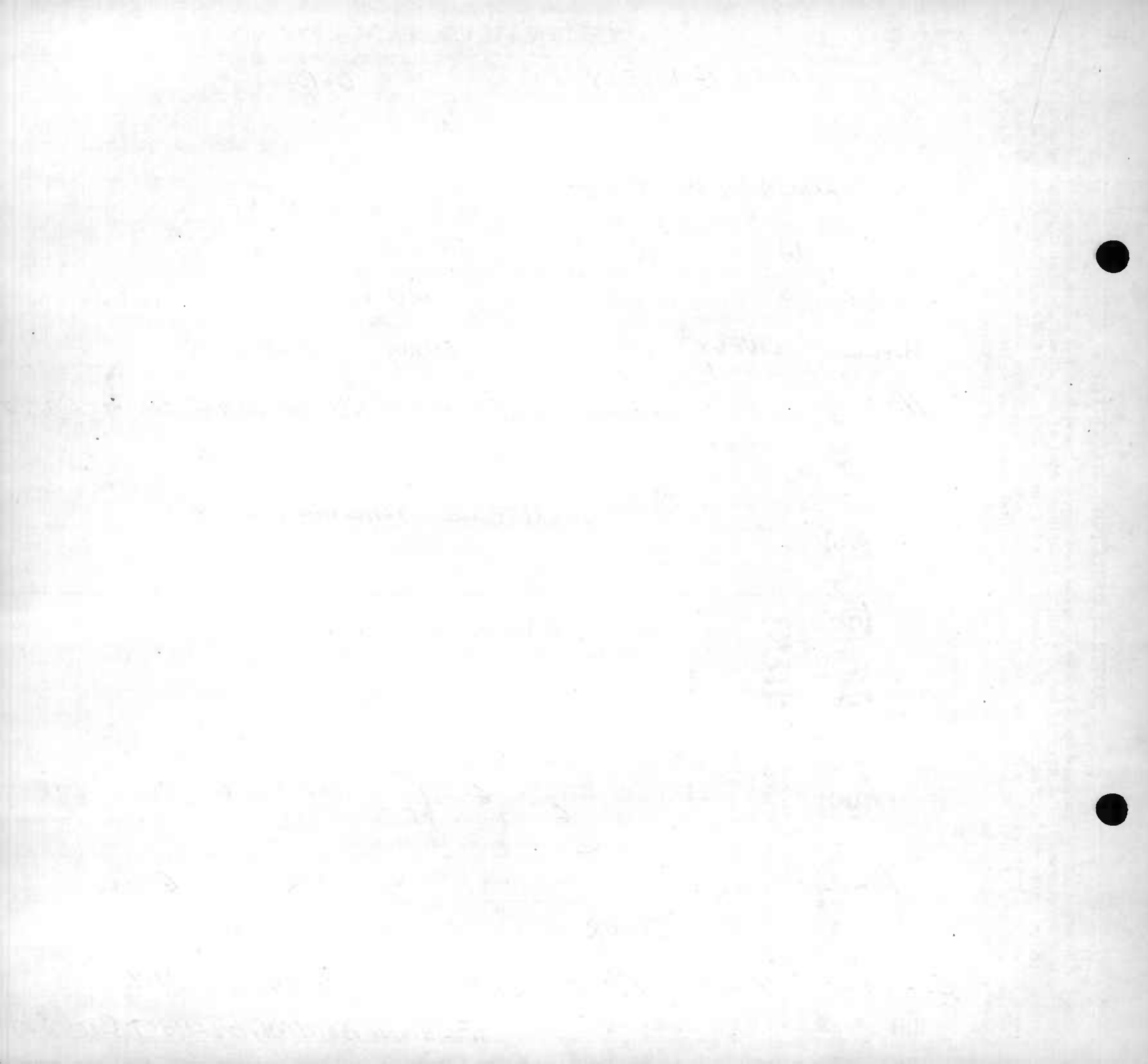
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6214	
BIRTH NO. 65 6214		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Ewell Laurence Middleton, Jr.</u>		2. DATE AND HOUR OF DEATH <u>6-10-65</u> <u>7:55 A.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Cambridge</u>		D. STREET ADDRESS (If rural, give location) <u>Star Route</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>4-27-09</u>	9. AGE (in years last birthday) <u>56</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist Self Employed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Ewell, Laurence Middleton, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Rhoda EmLen-Smith.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes World War 2</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Marian H. Ewell, Star Route, Cambridge Md.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>163X I</u> <u>Carcinoma of the lung with metastasis</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 25</u> 19 <u>65</u> to <u>June 10</u> 19 <u>65</u> , that (I) (we) lost saw the deceased alive on <u>June 16</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Rodney L. Brimhall</u> M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6-10-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR RODNEY L. BRIMHALL</u>		23D. ADDRESS <u>Union Memorial Hospital</u> M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>June 12, 1965</u>	24C. NAME of CEMETERY or CREMATORY <u>Old Trinity Churchyard</u>		24D. LOCATION (City, town, or county) (State) <u>Church Creek, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 14 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Cambridge, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No.	
65 6215		65 6215		2 ¹⁶ A. M.	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) JAMES G. LIVELY			2. DATE AND HOUR OF DEATH 6-10-65		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 FRANKLIN SQ. HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 19-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 111 S. CALHOUN ST.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 5-12-1896	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME HALL LIVELY		
14. MOTHER'S MAIDEN NAME FANNY LEATHERWOOD			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. ?			17. INFORMANT ADDRESS FANNIE E. JUSTICE, Box 25, ELlicott City, Md		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC HEART DISEASE					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETIS MELLITUS					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-9-65 to 6-10-65 , that (I) (we) last saw the deceased alive on 6-9-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Romeo A. Ferrer			23B. DATE SIGNED 6-10-65		
23C. PHYSICIAN'S NAME (Type) Romeo A. FERRER			23D. ADDRESS FRANKLIN SQ. HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/14/65		24C. NAME OF CEMETERY or CREMATORY MT PLEASANT	
24D. LOCATION (City, town, or county) (State) GAMBER, MD		25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS F.C. HIGGIN BOTHAM, ELlicott City, Md			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6216				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6216	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Linton, George E. S.</i>				2. DATE AND HOUR OF DEATH <i>6-11-65 4:05 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>CHURCH HOME HOSPITAL</i>				A. STATE <i>Baltimore</i> COUNTY <i>25-42</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>2859 Hollins Ferry Road</i>			
				D. STREET ADDRESS (If rural, give location) <i>Balto.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>7-27-11</i>	9. AGE (In years last birthday) <i>53</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foreman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Revere Copper & Brass</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George E.</i>				14. MOTHER'S MAIDEN NAME <i>Kathleen Hill</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family</i>		ADDRESS <i>Same</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Uremia</i>				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Kidney failure</i> <i>Gastric Cancer</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>None</i>							
19A. DATE OF OPERATION <i>5-2-65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma stomach</i>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>4-24-65</i> 19 to <i>6-11</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>6-11-65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>George J. Furman</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6-11-65</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <i>Church Home Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>6-14-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Meadowdale Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Elkridge Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 14 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>		25C. FUNERAL DIRECTOR <i>McNulty Funeral Home</i>		ADDRESS <i>237 Coopers Lane</i>	

Chas. W. Thompson

W. H. Moore

May 1902

George Thompson
Kilbury
West 114

George Thompson

2-2-02

6-11-02

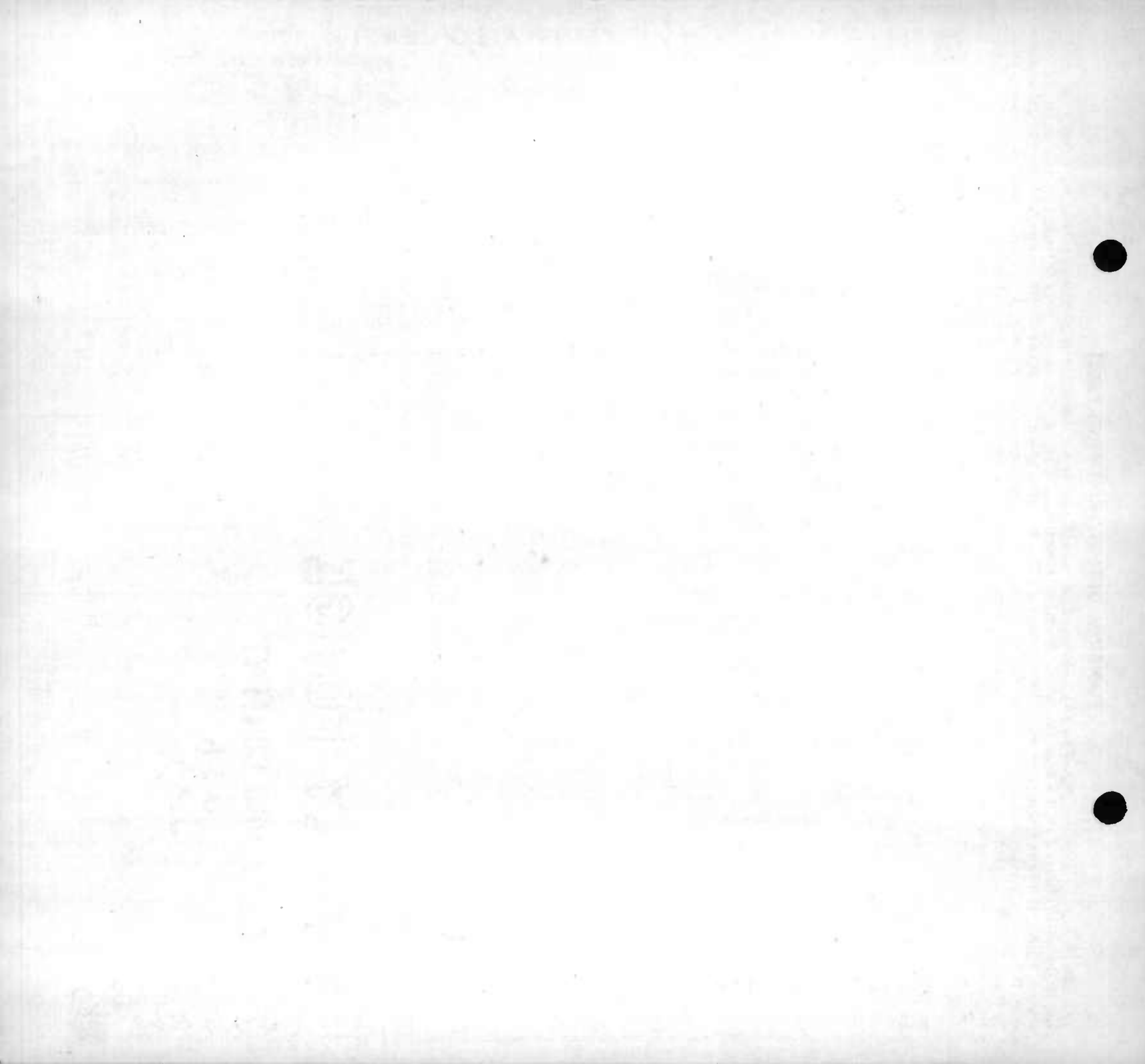
George Thompson

6-11-02
George Thompson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

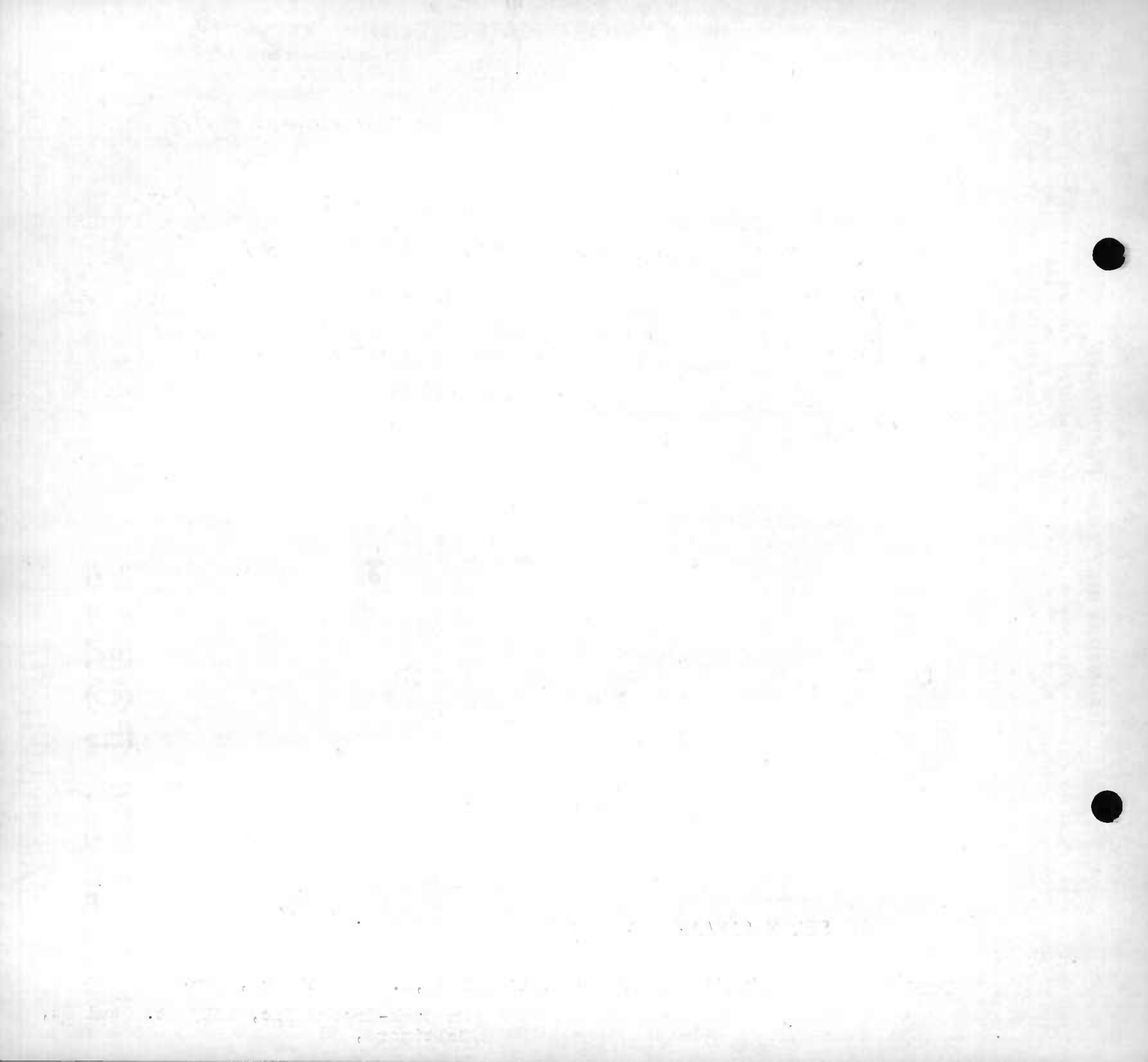
BIRTH NO. 65 6217				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 6217	
1. NAME OF DECEASED (Type or Print) KENDALL THOMAS EDWARD				2. DATE AND HOUR OF DEATH 6/10/65 1450 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 94 C. CITY OR TOWN (If outside city limits, write RURAL and give township) DADONA D. STREET ADDRESS (If rural, give location) 14 GRANADA RD. 02-00					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7/27/05	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles O. Kendall				14. MOTHER'S MAIDEN NAME NORA KENDALL = Florence Dadds					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS HOSPITAL RECORD					
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) THROMBOSIS OF @ MIDDLE CEREBRAL ARTERY				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) ARTERIO SCLEROSIS					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC BRONCHITIS & EMPHYSEMA				INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6/8 19 65 to 6/10 19 65 , that (I) (we) lost saw the deceased alive on 6/10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE L. Bradley Baker				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) L. BRADLEY BAKER				23D. ADDRESS M.D. UNIVERSITY HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Cremeration		24B. DATE 6-14-65		24C. NAME OF CEMETERY or CREMATORY horden Park Cemetery		24D. LOCATION (City, town, or county) (State) Balto, MD			
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR McGully Funeral H 237 Potosi			ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 6218		CERTIFICATE OF DEATH	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		BAGG, HAROLD EDWARD -		2. DATE AND HOUR OF DEATH 6/9/65 8:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Union Memorial Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY 1001 Beaumont Ave. 27-10 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore city D. STREET ADDRESS (If rural, give location) 1001 Beaumont Ave			
5. SEX M	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 3/26/08	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Canada	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES SIDNEY BAGG			14. MOTHER'S MAIDEN NAME MILLIE BROOKS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWII		16. SOCIAL SECURITY NO. 219-01-2674	17. INFORMANT Wife 1001 Beaumont Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19. CAUSE OF DEATH (A) DUE TO Mutant Antic Carcinoma from lung (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 8 months	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/29 1965 to 6/9 1965, that (I) (we) last saw the deceased alive on 6/9/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Soleim Samaan M.D.				23B. DATE SIGNED 6/9/65	
23C. PHYSICIAN'S NAME (Type) DR SOLEIM SAMAN SAMAN M.D.				23D. ADDRESS U. M. H.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/14/65		24C. NAME OF CEMETERY or CREMATORY Baltimore National Ceme.	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Wm Cook-Brooks Inc, 1217 St. Paul St, Baltimore, Md	



1
C-514

65 6219

BALTIMORE CITY HEALTH DEPARTMENT

65 6219

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ELIZABETH PATRICIA CAMPBELL

2. DATE AND HOUR PRONOUNCED DEAD

June 10, 1965 3:45 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Church Home & Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

238 S. Broadway

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Single

8. DATE OF BIRTH

Sept. 23, 1927

9. AGE (In years
last birthday)

37

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Waitress

10B. KIND OF BUSINESS OR INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

Rose Hill, Virginia

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Robert Campbell

14. MOTHER'S MAIDEN NAME

Martha Brittin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Robert Campbell

ADDRESS

Jonesville, Va.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Stab wound of abdomen with incision
DUE TO of liver.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, steel, office bldg,
etc.)

Cafe

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Norge Cafe, 238 S. Broadway

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

6 9 65 9:05p.m.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK☒

21F. HOW DID INJURY OCCUR?

Stabbed

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-10-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

June 11, 65

23C. NAME of CEMETERY or CREMATORY

Campbell Cemetery

23D. LOCATION

(City, town, or county)

Rose Hill, Virginia

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

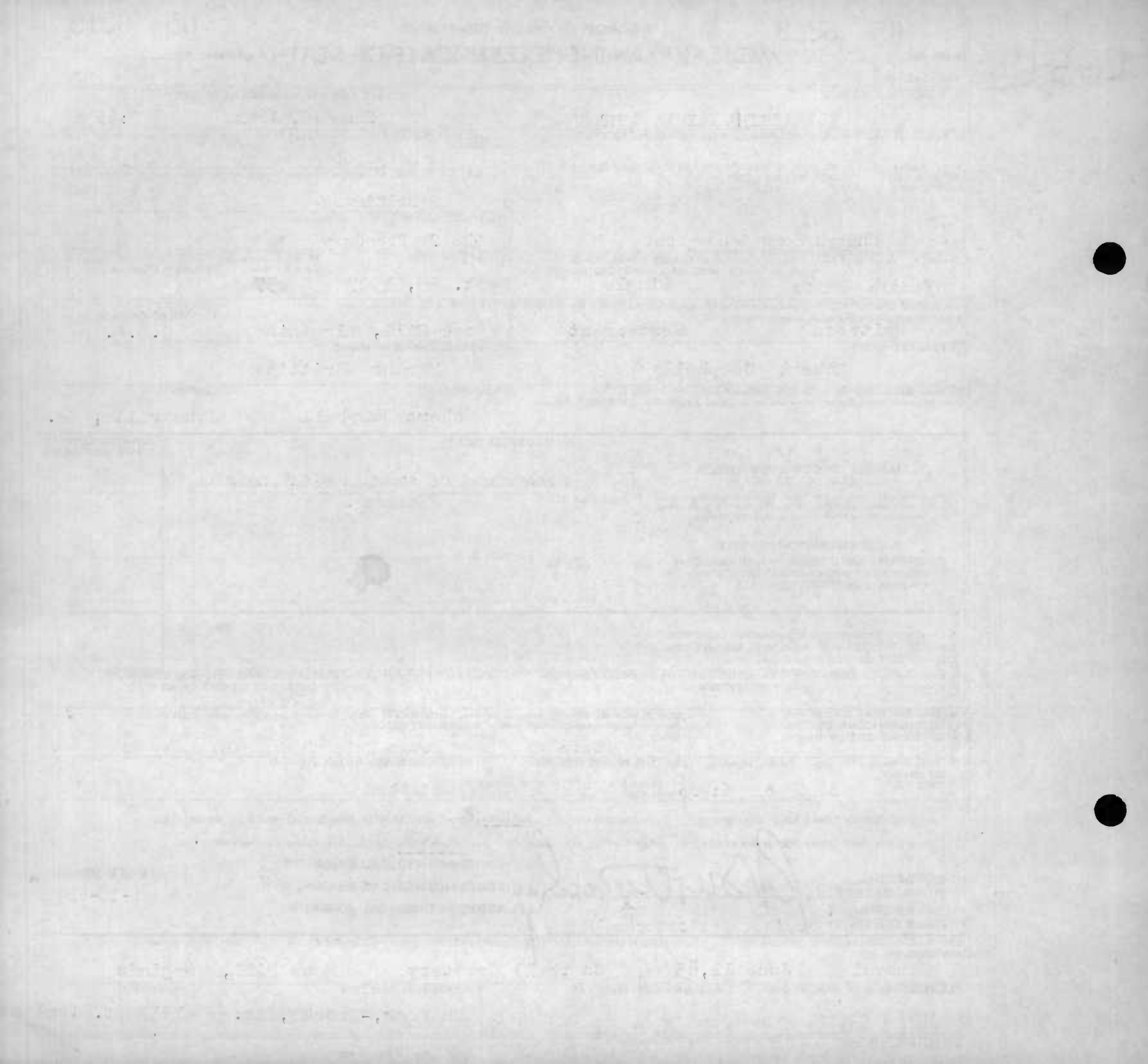
24C. FUNERAL DIRECTOR

ADDRESS

JUN 14 1965

Wm Cook, -Brooks, Inc.

1217 St. Paul St



BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 65 6220		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 6220	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
ARCHIE BENSON BULLINGTON		June 8, 1965 8:25 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		A. STATE Maryland	
		B. COUNTY	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 3255 Chestnut Avenue		13-05	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH March 4, 1901
9. AGE (In years last birthday) 64		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Axton, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ferd Bullington		14. MOTHER'S MAIDEN NAME Hattie Barker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Annie Bullington		ADDRESS 3255 Chestnut Ave.	
18. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Removal		23B. DATE June 9, 1965	
23C. NAME OF CEMETERY or CREMATORY Greenlawn Cemetery		23D. LOCATION (City, town, or county) (State) China Grove, N. C.	
24A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		24B. NAME OF REGISTRAR Robert E. Farley, M.D.	
24C. FUNERAL DIRECTOR Wm Cook-Brooks, Inc.		ADDRESS 1217 St. Paul St.	

WALTER H. COFFIN

PAID 10/10/1918

Walter H. Coffin

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		65 6221	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
MARION H. COURTNEY			June 9, 1965 3:10 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			1207 N. Calvert Street		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Female	White	Widowed	March 15, 1909	56	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Manager		Jefferson Apts.		Baltimore, Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William Hunt			Gertrude Sanders		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		213-34-6669		William Hunt Earle Court Apts.	
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
(A) Portal Cirrhosis. DUE TO					
(B) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		6/12/65		Lorraine Park	
				Baltimore County Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
JUN 14 1965		Robert E. Feltner		Wm. Cook-Brooks Inc. 1217 St. Paul St.	

WALLER

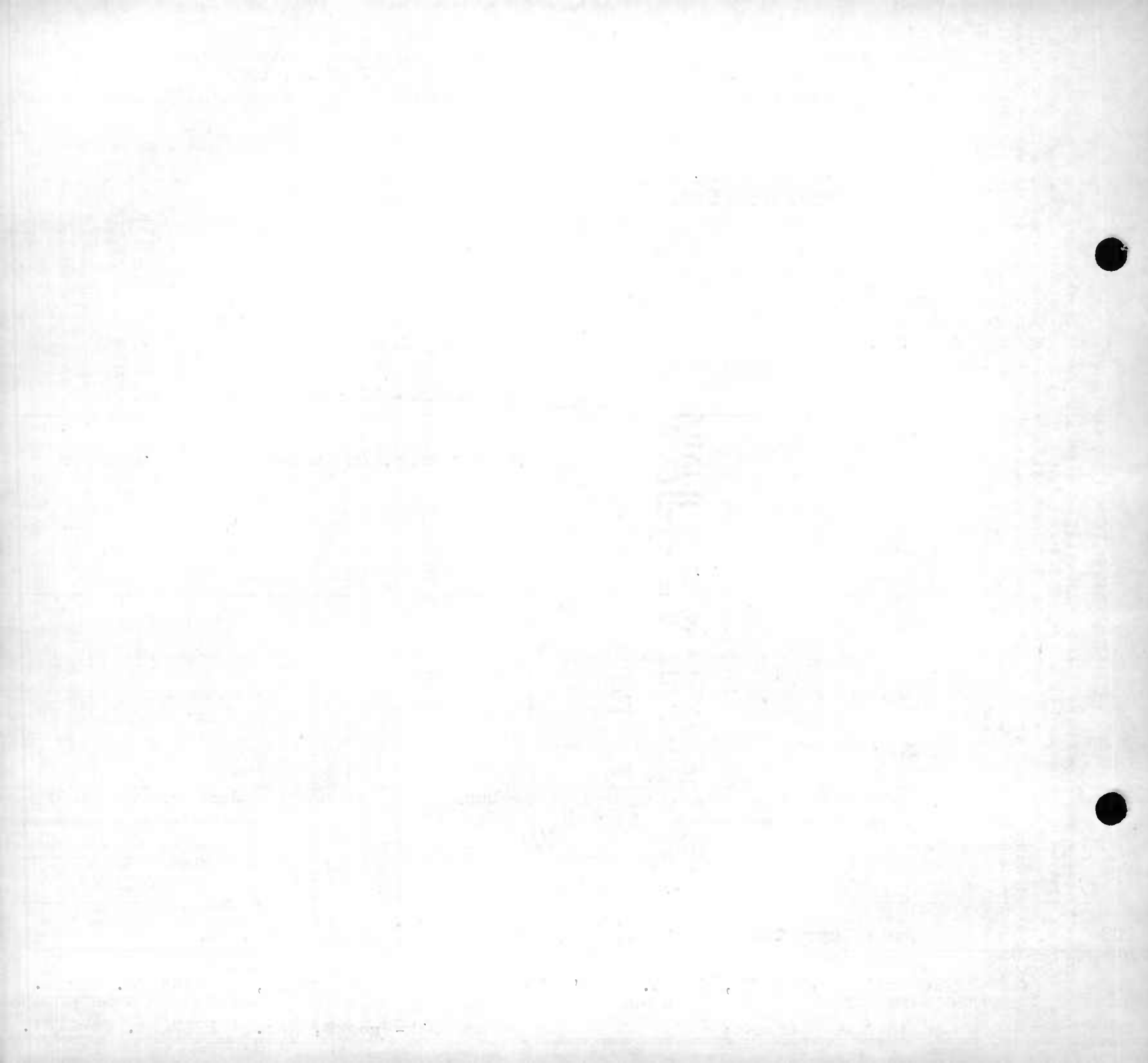
CHIEF

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

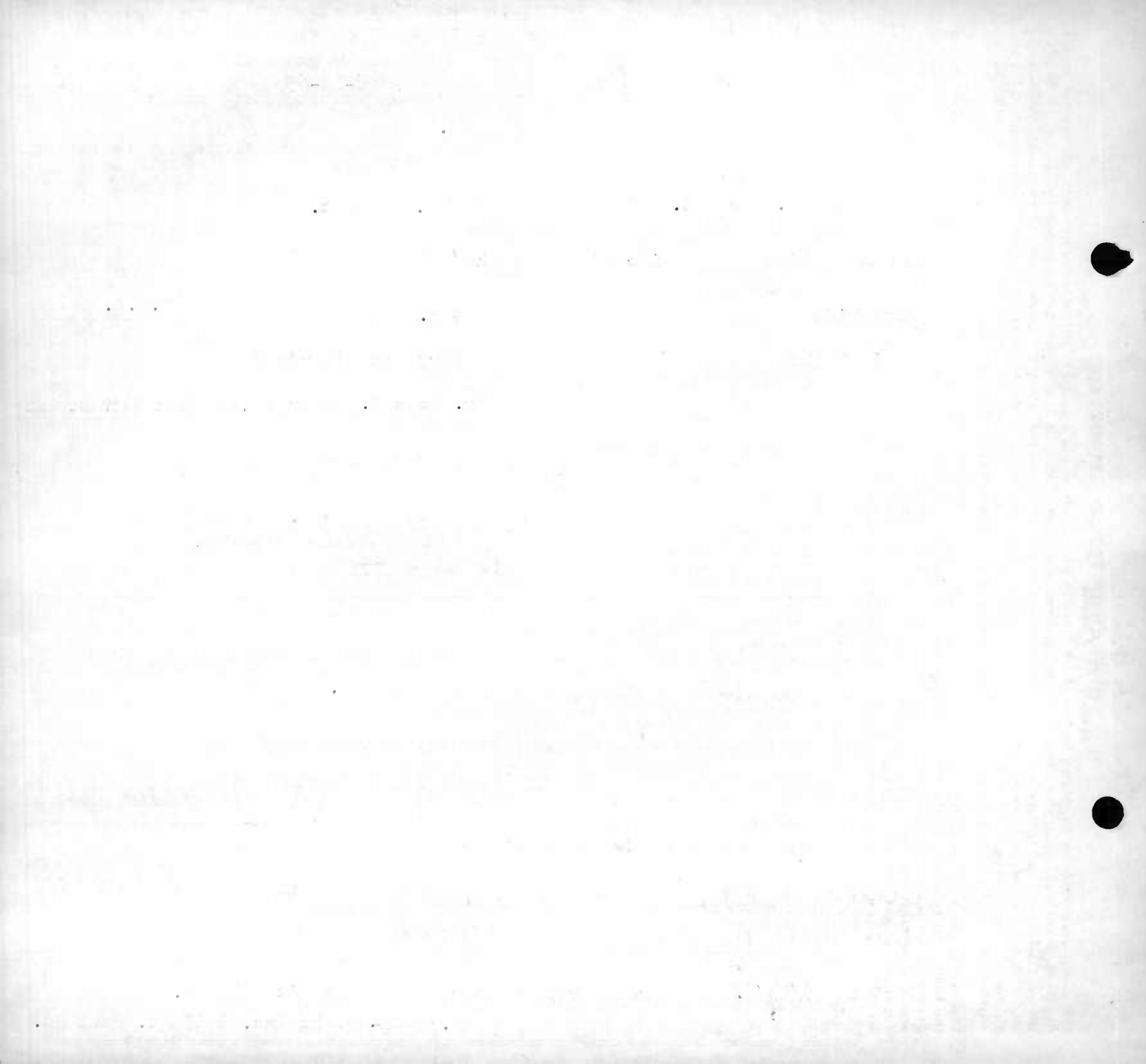
BIRTH NO. 65 6222		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6222	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH June 10, 1965 9:45 P M.	
1. NAME OF DECEASED (Type or Print) JOHN ANDREW ADVENT					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pa. B. COUNTY 1-30			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st St.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Grays Landing D. STREET ADDRESS (If rural, give location) Box 62			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH 4/30/10	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Czechoslovakia	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John J. Advent		14. MOTHER'S MAIDEN NAME Mary Klotz			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 176-033-1789		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 200.1 I Lymphosarcoma, generalized		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Over 2 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Mar. 16 1965 to June 10 1965, that (1) (we) last saw the deceased alive on June 10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Aaron Lupovitch		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/11/65	
23C. PHYSICIAN'S NAME (Type) Aaron Lupovitch, Surgeon (R)		23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE June 11, 65		24C. NAME OF CEMETERY or CREMATORY St. Mary's Cemetery	
24D. LOCATION Leckrone, Fayette Co. Penna.					
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Wm Cook-Brooks, Inc. 1217 St. Paul St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

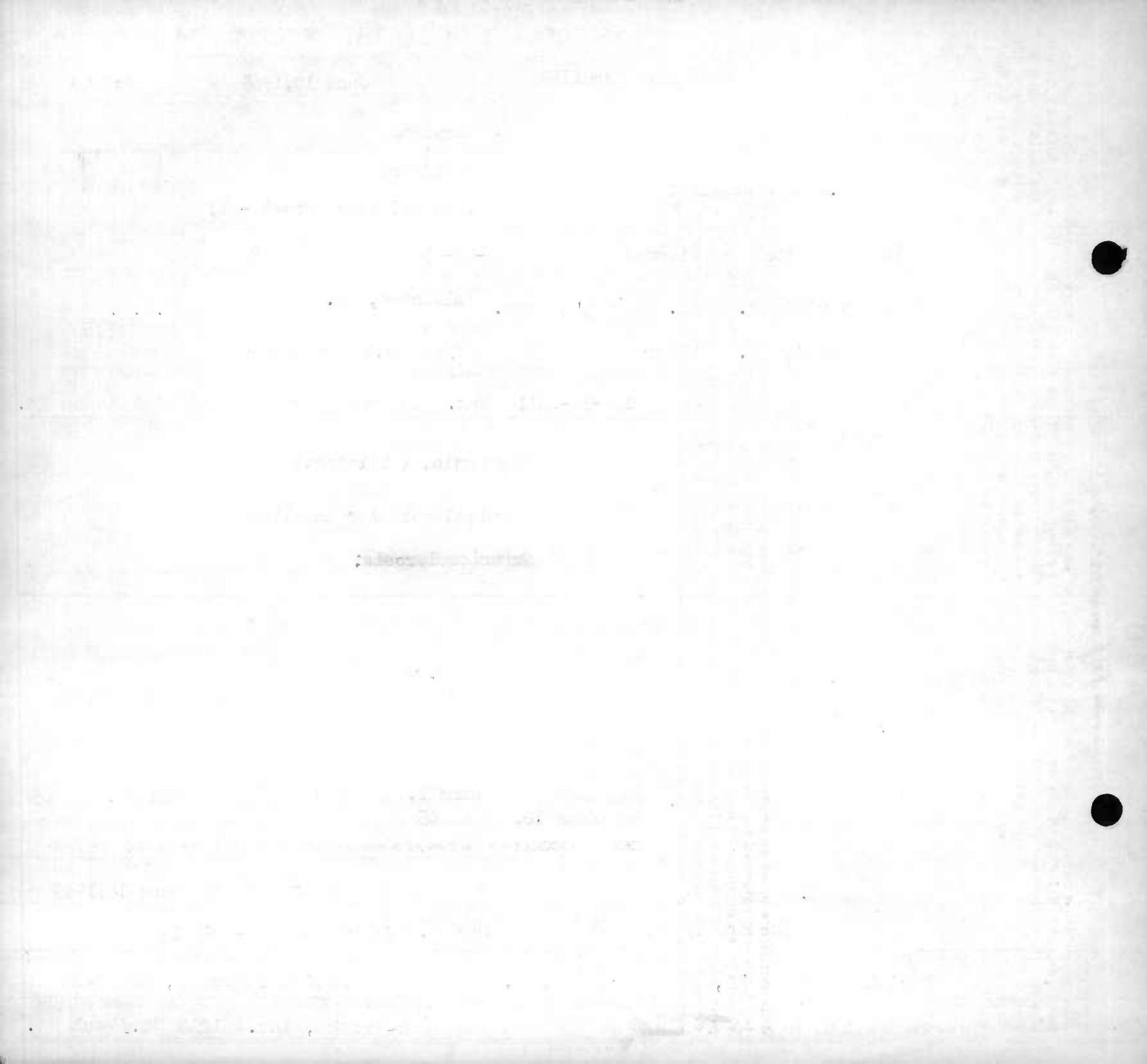
BIRTH NO. 65 6223				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6223	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Bertha Edwards				2. DATE AND HOUR OF DEATH 6-10-65 5:40 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Century Nursing Home 102 N. Paca St.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 9-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 606 E. 34th St.			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10/2/1878	9. AGE (In years last birthday) 86	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Hughes				14. MOTHER'S MAIDEN NAME Mary Ann Edwards			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. John C. Edwards, 606 East 34th Street			
18. I 722.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH (A) DUE TO Cardio-Respiratory Failure Coronary Heart Failure (B) DUE TO Atherosclerotic C.U.I.D. Gen. Atherosclerosis (C) Same as INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb 9 1965 to June 10 1965, that (I) (we) last saw the deceased alive on June 10 1965 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Willard Applofeld M.D.				23B. DATE SIGNED 6/10/65		23C. PHYSICIAN'S NAME (Type) Willard Applofeld M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/14/65		24C. NAME OF CEMETERY or CREMATORY Grand Army Cemetery		24D. LOCATION (City, town, or county) (State) Summit Hill Pa.	
25A. DATE REC'D BY HEALTH DEPT. JUN 14 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. 1217 St. Paul St.		ADDRESS 21202	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 6224</u>	
BIRTH NO. <u>65 6224</u>		M.E. CASE NO. <u>65 6224</u>		1. NAME OF DECEASED (Type or Print) <u>GOSNELL, CAROLINE</u>		2. DATE AND HOUR OF DEATH <u>June 10, 1965</u> <u>6:00 A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Joseph Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1544 Holbrook Street - 13</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED</u>	8. DATE OF BIRTH <u>4-27-93</u>	9. AGE (In years last birthday) <u>72</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Switch Board Oper.</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Switch Board Oper.</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>St. Joseph's Hosp.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Louis M. Zeller</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Buechner</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>217-18-0811</u>		17. INFORMANT <u>Mrs. Florence Carroll</u>		
					ADDRESS <u>210 Highmeadow Rd.</u>		
18. <u>332X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia, (bilateral)</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cerebral-vascular Embolism</u> <u>Arteriosclerosis</u>				CAUSE OF DEATH (A) <u>Pneumonia, (bilateral)</u> DUE TO (B) <u>Cerebral-vascular Embolism</u> DUE TO (C) <u>Arteriosclerosis</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u>				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>None</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 1, 19 65</u> to <u>June 10, 19 65</u> , that (I) (we) last saw the deceased alive on <u>June 10, 19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.							
23A. SIGNATURE <u>Teodoro R. Carangal</u> M.D.						23B. DATE SIGNED <u>June 10, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Teodoro R. Carangal</u> M.D.						23D. ADDRESS <u>1400 N. Coline Street - 21213</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>June 11, 65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore County, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 14 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm Cook-Brooks, Inc. 1217 St. Paul St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6225				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6225	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
				Robert Watkins			
2. DATE AND HOUR OF DEATH				June 13, 1965 3:45a M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Provident Hospital 1514 Division Street Baltimore, Maryland 21217				Maryland			
5. SEX				6. RACE			
Male				Negro			
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH			
?				July 10, 1917			
9. AGE (In years lost birthday)				10. AGE (In years lost birthday)			
44				44			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
Porter				Hotel			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Virginia				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
unknown				Annio Watkins			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
no				212-09-9910			
17. INFORMANT				18. CAUSE OF DEATH			
Bertie Harris-landlady				same			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				UREMIA			
ANTECEDENT CAUSES				(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CHRONIC PNEUMONITIS			
II				(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
0				no			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
no							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from June 11, 1965 to June 13, 1965, that (I) (we) last saw the deceased alive on June 13, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Hollis Seunarine, M.D.				June 14, 1965			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Hollis Seunarine				1514 Division Street. Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				6-15-65			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Family Plot				Victoria, Virginia			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
JUN 15 1965				Robert E. Farkner, M.D.			
25C. FUNERAL DIRECTOR				25D. ADDRESS			
Earl Gilmore				1827 W. North Ave			

74

James H. H. H.

James H. H. H.

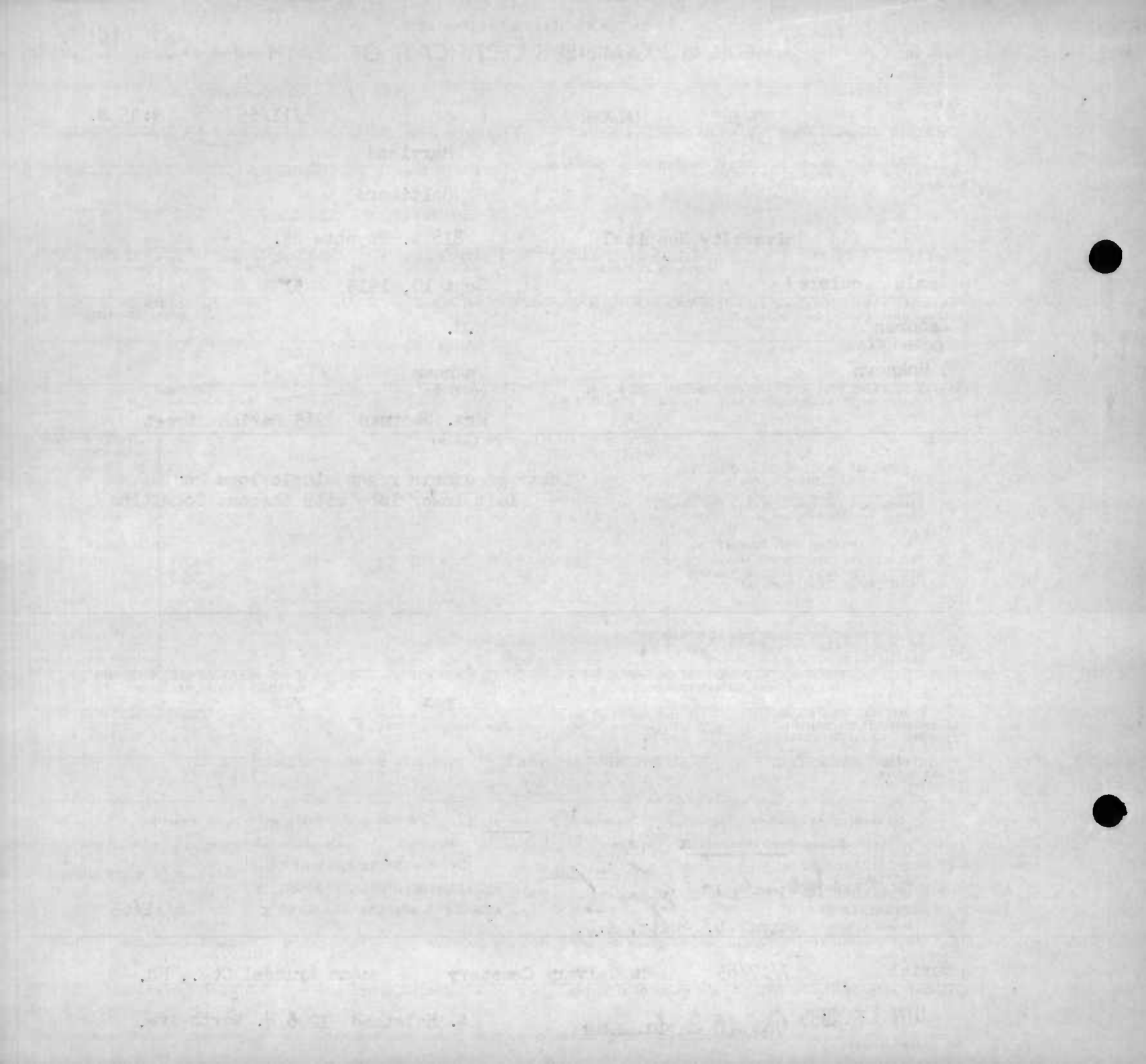
James H. H. H.

James H. H. H.

BIRTH NO. 58-30425		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 65 6226	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
Ronald Goines				2. DATE AND HOUR PRONOUNCED DEAD			
June 13, 1965				1:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE			
City Hospitals				Maryland			
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				867 Boyd Street			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Male		Negro		Child		10/14/58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		9. AGE (In years last birthday)	
				Baltimore Md		6	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Irvin Goines				Lillian Ashby			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						Mrs Lillian Goines 867 Boyd St	
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH							
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)							
(A) Bronchial asthma							
DUE TO							
(B) DUE TO							
(C) DUE TO							
INTERVAL BETWEEN ONSET AND DEATH							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				yes		yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type) John E. Adams, M.D.				ASSISTANT MEDICAL EXAMINER		June 13, 1965	
ASSOCIATE MEDICAL EXAMINER							
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		6/16/65		Mt Calvary Cemetry		A A County Md	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
JUN 15 1965		Robert E. Farber, M.D.		Adolphus Halstead		918 Druid Hill Ave	

WALTER B. BOWEN

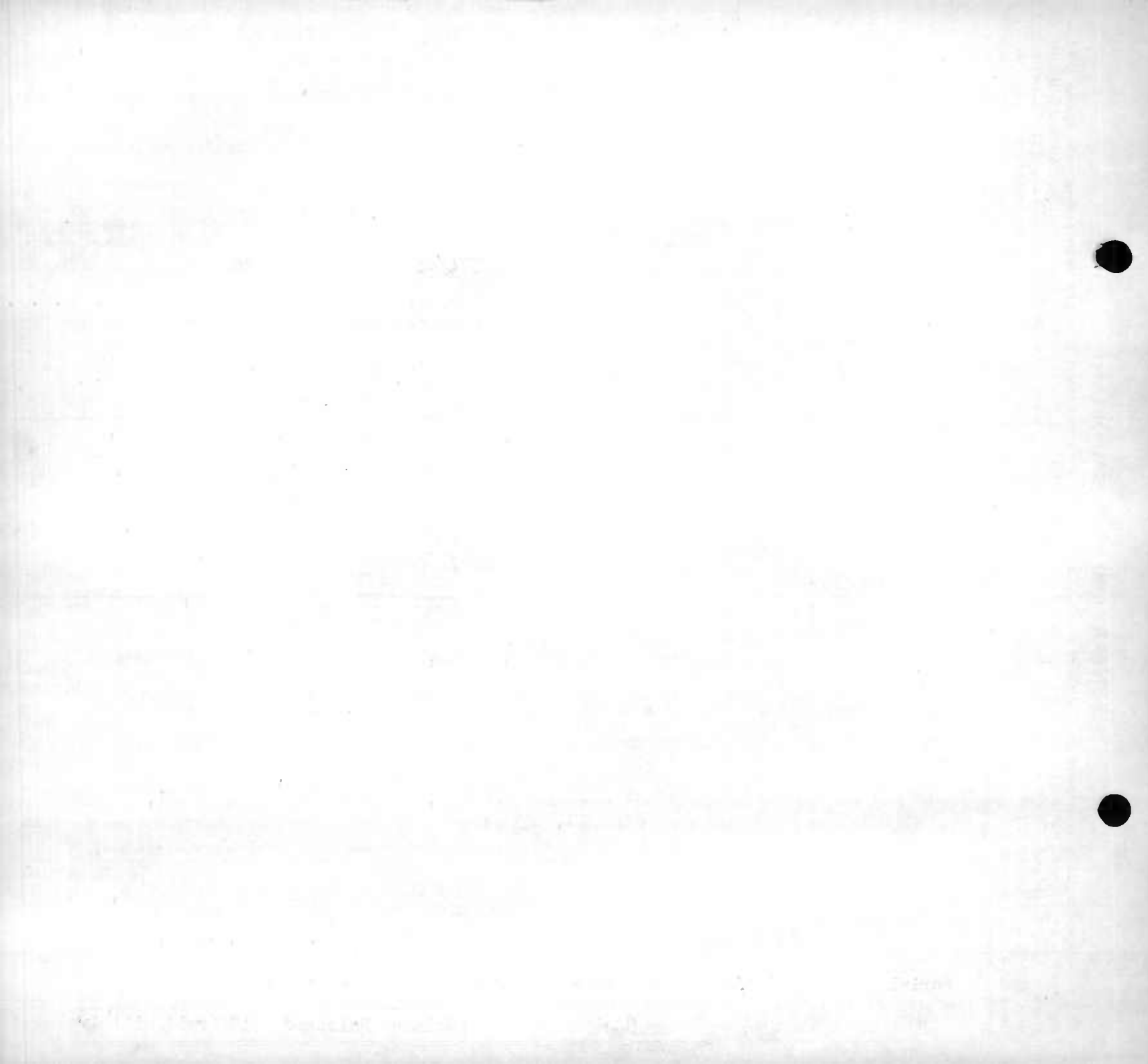
BIRTH NO. 65 6227		BALTIMORE CITY HEALTH DEPARTMENT		65 6227	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
HOWARD WALKER			6/11/65 9:45 a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
University Hospital			Maryland		
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
			Baltimore 18-01		
			D. STREET ADDRESS (If rural, give location)		
			818 W. Fayette St.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
male	colored		Sept 10, 1913	51	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer				N.C.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Unknown			Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Mrs. Sherman 915 Parish Street	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(A) DUE TO Lobar pneumonia right middle lobe and left lower lobe with abscess formation (B) DUE TO (C)		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER			
Werner U. Spitz, M.D.		ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>		6/11/65	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
Burial		7/17/65		Mt Calvary Cemetery	
				23D. LOCATION (City, town, or county) (State)	
				Ann Arundel Cty., Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
JUN 15 1965		Robert E. Farley		A. Halstead 1206 W. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6228				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6228	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <div style="text-align: center;">President Davis</div>				2. DATE AND HOUR OF DEATH <div style="text-align: center;">June 11, 1965 11:50am</div>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <div style="text-align: center;">Provident Hospital</div>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY <div style="text-align: center;">Maryland 11-03</div> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <div style="text-align: center;">Baltimore</div> D. STREET ADDRESS (If rural, give location) <div style="text-align: center;">454 St. Mary's Street</div>			
5. SEX <div style="text-align: center;">Male</div>	6. RACE <div style="text-align: center;">Negro</div>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <div style="text-align: center;">widowed</div>	8. DATE OF BIRTH <div style="text-align: center;">3/4/05</div>	9. AGE (In years lost birthday) <div style="text-align: center;">60</div>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center;">none</div>		11. BIRTHPLACE (State or foreign country) <div style="text-align: center;">Virginia</div>		12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center;">U.S.A.</div>	
13. FATHER'S NAME <div style="text-align: center;">unknown</div>				14. MOTHER'S MAIDEN NAME <div style="text-align: center;">unknown</div>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <div style="text-align: center;">Anna Mae Spencer-daughter</div>		ADDRESS <div style="text-align: center;">905 Wicklow Rd</div>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <div style="text-align: center;">492X1</div>				CAUSE OF DEATH (A) <div style="text-align: center;">Cardiovascular Accident-Thrombosis</div> DUE TO (B) <div style="text-align: center;">Congestive Heart Failure</div> DUE TO (C) <div style="text-align: center;">Pneumonitis</div>		INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <div style="text-align: center;">0</div>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <div style="text-align: center;">no</div>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <div style="text-align: center;">June 5, 1965</div> 19 to <div style="text-align: center;">June 11,</div> 19 <div style="text-align: center;">65</div> , that (I) (we) last saw the deceased alive on <div style="text-align: center;">June 11, 1965</div> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <div style="text-align: center;">Robert Blackmon</div>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <div style="text-align: center;">June 12, 1965</div>	
23C. PHYSICIAN'S NAME (Type) <div style="text-align: center;">Robert Blackmon</div>				23D. ADDRESS M.D. <div style="text-align: center;">1514 Division St. Baltimore, Maryland</div>			
24A. BURIAL CREMATION, REMOVAL (Specify) <div style="text-align: center;">Burial</div>		24B. DATE <div style="text-align: center;">6/17/65</div>		24C. NAME of CEMETERY or CREMATORY <div style="text-align: center;">Mt Auburn Cemetry</div>		24D. LOCATION (City, town, or county) (State) <div style="text-align: center;">Baltimore Md</div>	
25A. DATE REC'D BY HEALTH DEPT. <div style="text-align: center;">JUN 15 1965</div>		25B. NAME OF REGISTRAR <div style="text-align: center;">Robert E. Farley</div>		25C. FUNERAL DIRECTOR ADDRESS <div style="text-align: center;">Adolphus Halstead 918 Druid Hill Ave</div>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 6229		CERTIFICATE OF DEATH		Registered No. 65 6229	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				LAWSON, ALMETTA		13 JUNE 1965		11 25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY			
Sinai Hospital				Maryland		4-02			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
				Baltimore					
				D. STREET ADDRESS (If rural, give location)					
				624 W. Saratoga, 21201					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
F	N	Married	8/27/22	42					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		—		Virginia		USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
?				?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Unknown		?		Hospital record					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) HEPATIC DECOMPENSATION DUE TO					
ANTECEDENT CAUSES				(B) HEPATOMA DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Hepatic cirrhosis					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS IN CERTIFYING CAUSES OF DEATH?			
0		—							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (this hospital) attended the deceased from 10 JUNE 1965 to 13 JUNE 1965, that (we) lost saw the deceased alive on 13 JUNE 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Barry M. Cohen				13 JUNE 65					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		6/18/65		Mt. Calvary Cemetery		A A County Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUN 15 1965		Robert E. Fisher, Jr.		Adolphus Halstead		918 Druid Hill Ave			

65 6230

BALTIMORE CITY HEALTH DEPARTMENT

65 6230

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Marie E. James

2. DATE AND HOUR PRONOUNCED DEAD

June 13, 1965

12:05 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

628 N. Gilmor Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SEPARATED

8. DATE OF BIRTH

8-19-20

9. AGE (In years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

Pot Family

11. BIRTHPLACE (State or foreign country)

BALTIMORE MD

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

FANNICE JOHNSON

14. MOTHER'S MAIDEN NAME

PDA PINDER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

215-22-5920

17. INFORMANT

ADDRESS

FLORENCE JENKINS - NEW YORK, NY

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(A) Massive hemoptysis

DUE TO

far advanced, active, disseminated
tuberculosis

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 13, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

6/16/65

23C. NAME OF CEMETERY or CREMATORY

Arboretum Burial Park

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 15 1965

John E. Adams

Margaret P. Hays 638 N. Gilmor St

WALLLEY PROPOSE

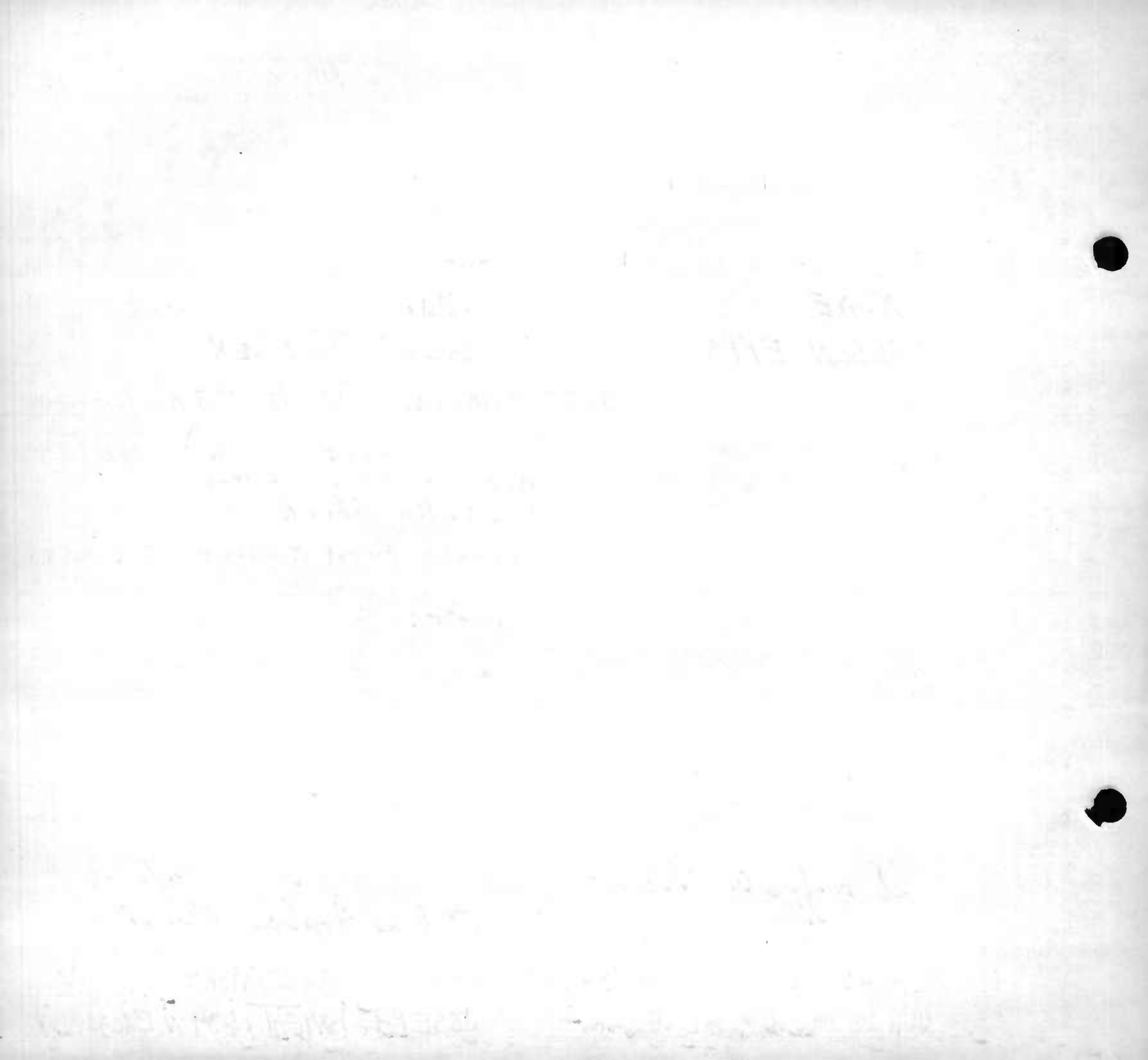
PARADYNT

1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

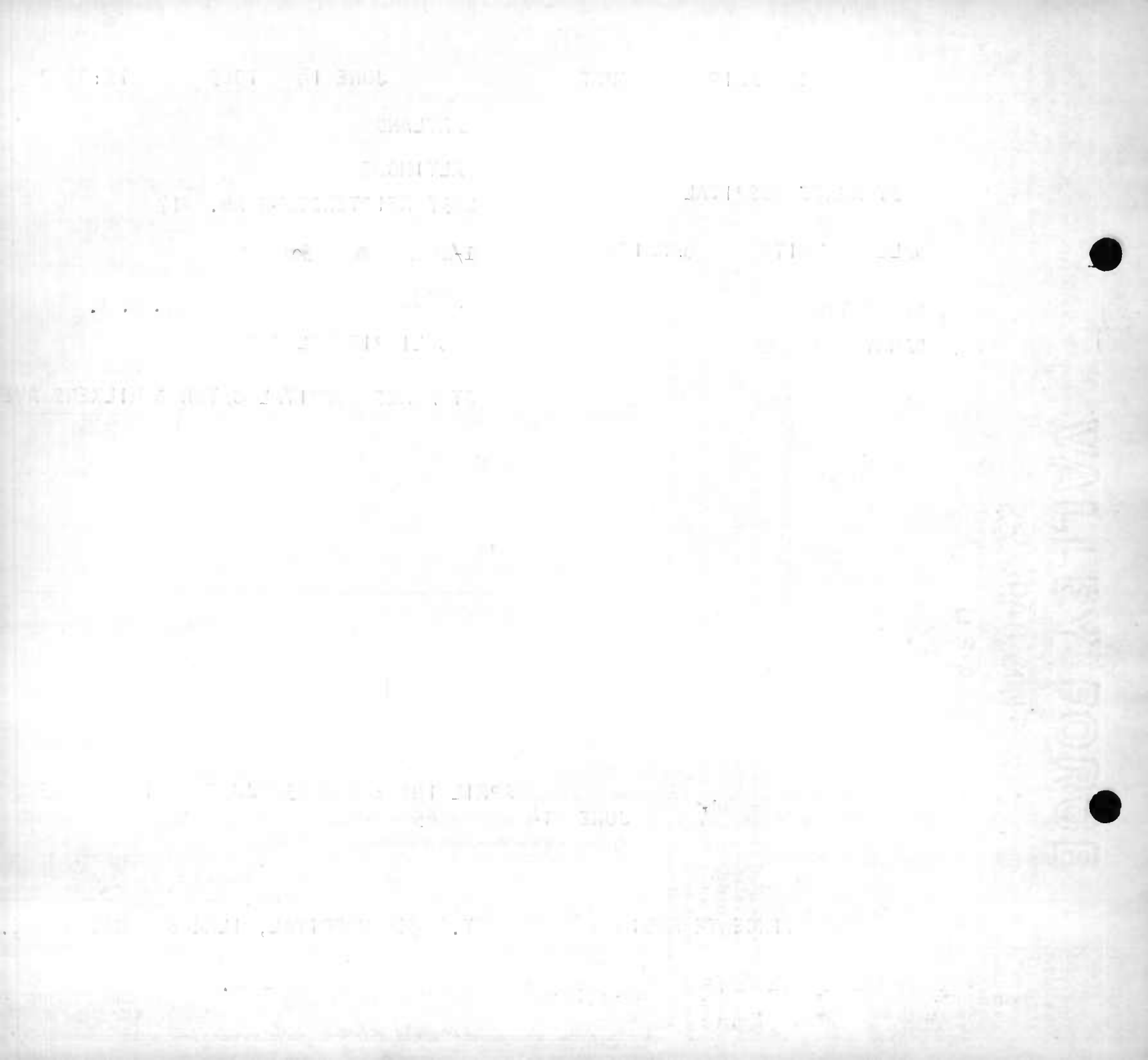
BIRTH NO. 65 6231		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6231	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 6/11/65 3:30 P.M.	
1. NAME OF DECEASED (Type or Print) Ethel Smith					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1713 RUTLAND AVENUE			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-27-13	9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME COLSON EPPS		14. MOTHER'S MAIDEN NAME SALLY TUCKER		17. INFORMANT ADDRESS ARLENE FIELDS 1713 RUTLAND AVE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-20-2555			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO Cardiac Arrest 2nd to Acute Pulmonary Edema		30 minutes	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Insulin Shock		7 hours	
		(C) Chronic Renal Failure		2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/11 19 65 to 6/11 19 65, that (I) (we) last saw the deceased alive on 6/11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Douglas W. Macrae		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/11/65	
23C. PHYSICIAN'S NAME (Type) DOUGLAS W. MACRAE		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-16-65		24C. NAME OF CEMETERY or CREMATORY BALTO-NATIONAL	
24D. LOCATION BALTIMORE		24E. (City, town, or county) (State) Md			
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965		25B. NAME OF REGISTRAR Paul E. Fisher		25C. FUNERAL DIRECTOR JOSEPH KNIGHT 1639 N. BROADWAY	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6232		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6232	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
KOUVARIS GUST		JUNE 14 1965		12:00 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
ST AGNES HOSPITAL		MARYLAND			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		2237 REISTERSTOWN RD. #17			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
MALE	WHITE	MARRIED	1/17/1885	80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
House Painter				U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
SAMMY Kouvaris		CALIOPIE ZELOS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No None				ST AGNES HOSPITAL CATON & WILKENS AVE	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 14 19 65 to JUNE 14 19 65, that (I) (we) last saw the deceased alive on JUNE 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
VINCENTE RUBIN				6/14/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		ST. AGNES HOSPITAL, WILKENS & CATON AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		6/17/1965		Greek Orthodox Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Woodlawn, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 15 1965		Robert E. Taylor, M.D.		Wm. J. Jickel, 21217 Balto. rd. north Pa. ave.	



BIRTH NO.

65

(MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH F. BRUCE

2. DATE AND HOUR PRONOUNCED DEAD

6/10/65 5:25 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, with RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

410 W. Franklin St. 21201

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Single

8. DATE OF BIRTH

July 15, 1895

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Clerk

10B. KIND OF BUSINESS OR INDUSTRY

U. S. Gov't

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Robert B. Bruce

14. MOTHER'S MAIDEN NAME

Grace Barnes

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War I

16. SOCIAL
SECURITY NO.

214-14-1857

17. INFORMANT

Mrs. John Marshall Baltimore, Md. 17

ADDRESS

Marlborough Apts.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

6/11/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/14/1965

23C. NAME of CEMETERY or CREMATORY

Druid Ridge Cemetery

23D. LOCATION

(City, town, or county)

Pikesville, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 15 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Wm. J. Johnson & Sons

ADDRESS

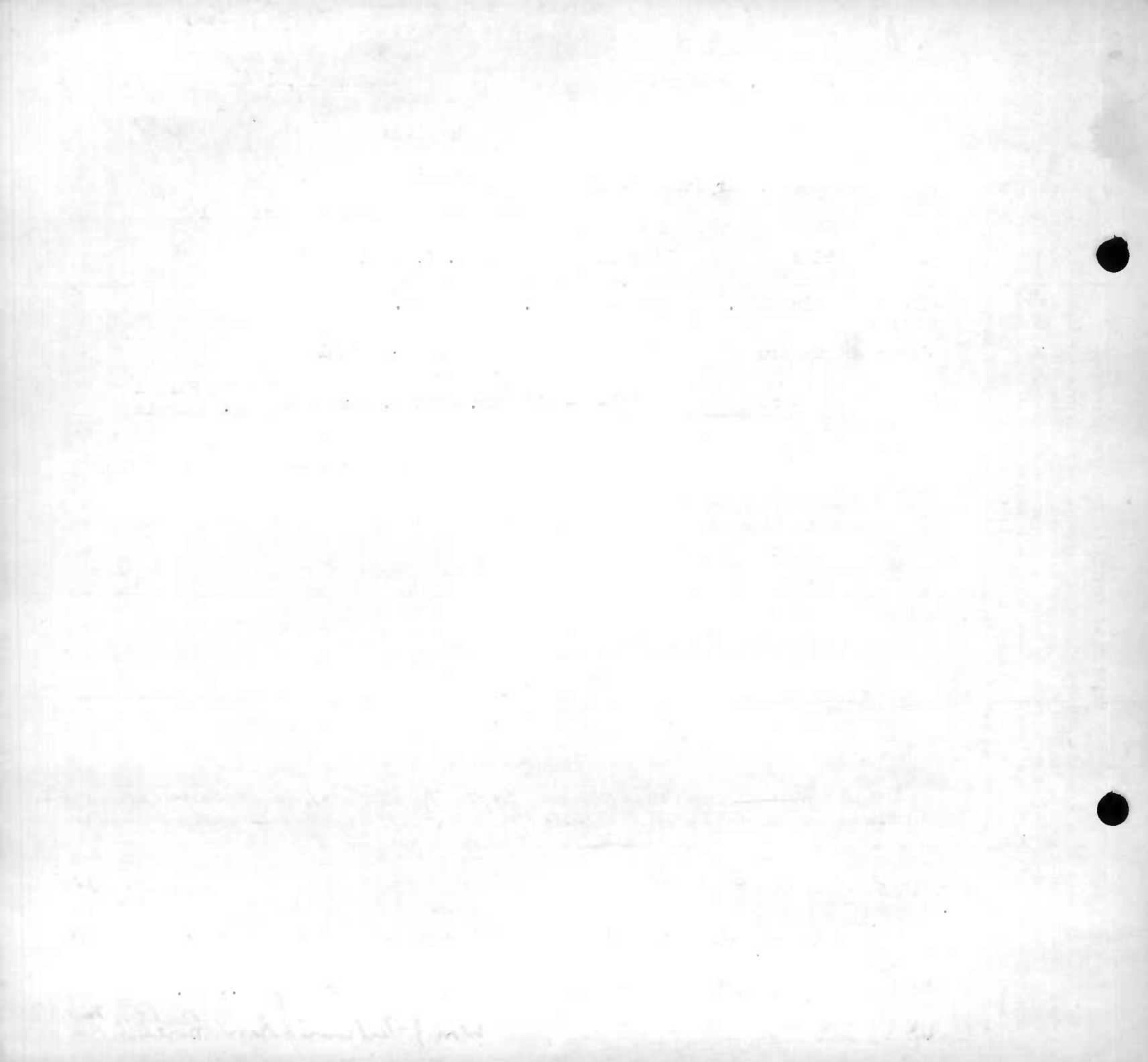
Baltimore, Md. 21217

21-11-11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

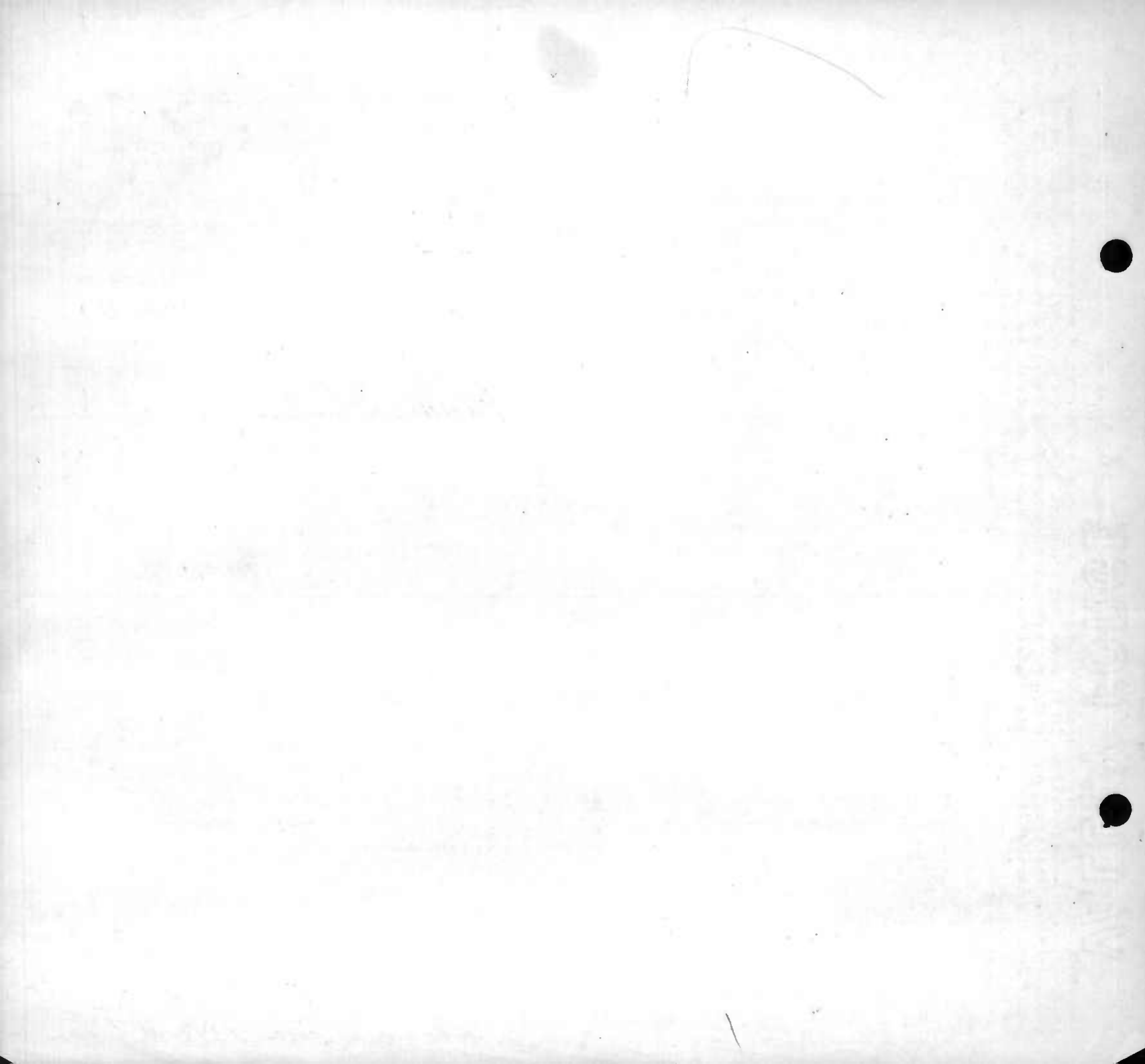
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6234	
BIRTH NO. 65 6234		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) James H. Crawford			2. DATE AND HOUR OF DEATH June 12, 1965 12:30 p. m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 15-09		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2706 Chelsea Terrace Baltimore, Maryland 21216			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 2706 Chelsea Terrace 16		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Feb. 1, 1891	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired District Eng.		10B. KIND OF BUSINESS OR INDUSTRY Travelers Ins.	11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME James H. Crawford			14. MOTHER'S MAIDEN NAME Martha Diehl		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 223-05-8026	17. INFORMANT ADDRESS Mr. John E. Crawford San Rafael California		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I Coronary occlusion			CAUSE OF DEATH (A) Coronary occlusion DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Coronary arteriosclerotic heart dis. DUE TO		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Sept. 7, 1961 to June 12, 1965 , that (I) (we) last saw the deceased alive on June 1, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Abraham B. Hurwitz			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 14, 1965
23C. PHYSICIAN'S NAME (Type) ABRAHAM B. HURWITZ			23D. ADDRESS 7501 LIBERTY ROAD, BALTIMORE MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/15/1965	24C. NAME OF CEMETERY or CREMATORY Winters Church Cemetery	24D. LOCATION (City, town, or county) (State) Carroll Co., Md.		
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR Wm. J. Taylor & Sons ADDRESS Baltimore Md. 17			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6235		BALTIMORE CITY HEALTH DEPARTMENT		65 6235	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <i>Brinkley, Jean W.</i>		2. DATE AND HOUR OF DEATH <i>6-12-65 2:34 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>19-01</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE, MD</i>			
		D. STREET ADDRESS (If rural, give location) <i>524 N. GILMORE STREET</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED <i>MARRIED</i>	8. DATE OF BIRTH <i>6-23-02</i>	9. AGE (In years lost birthday) <i>62</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Ind.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>CARLETON WINSTON</i>		14. MOTHER'S MAIDEN NAME <i>MARGARET DORSEY</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Fannie Stanton 56 Perryman St</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cardiovascular failure</i>		CAUSE OF DEATH (A) DUE TO <i>Intestinal Perforation few hours</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <i>Carcinoma Rectum few months</i>		(B) DUE TO <i>Carcinoma Rectum few months</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>03-18-65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma Rectum</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if this hospital) attended the deceased from <i>5-1-65</i> to <i>6-12-65</i> , that (we) last saw the deceased alive on <i>6-12-65</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Hormoz Azar</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6-12-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Hormoz Azar</i>		M.D.		23D. ADDRESS <i>Johns Hopkins Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-17-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Daring Cem.</i>	
24D. LOCATION <i>Howard Co., 2nd</i>					
25A. DATE RECD BY HEALTH DEPT. <i>JUN 15 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>George G. Kula</i>	
				ADDRESS <i>1348 N. Calton St</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6236	
BIRTH NO. 65 6236		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SR. M. CONCEPTION (CARMEN VENTOSA)		2. DATE AND HOUR OF DEATH 6/14/65 1:16 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE BALTIMORE, MARYLAND B. COUNTY Balt		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27, MARYLAND 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL		D. STREET ADDRESS (If rural, give location) 701 GUN ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 10-28-87	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RELIGIOUS - NUN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUBA	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME ISABEL VENTOSA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS OF ST AGNES HOSP. CATON AND WILKENS AVENUES	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Generalized Peritonitis Acute Intestinal Obstruction		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6-10-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-10-1965 to 6-14-1965 , that (I) (we) lost saw the deceased alive on 6-14-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edgardo R. Beltran		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-14-65	
23C. PHYSICIAN'S NAME (Type) E.R. BELTRAN		M.D.		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 16/65		24C. NAME of CEMETERY or CREMATORY New Cathedral Cem	
24D. LOCATION (City, town, or county) (State) Baltimore, Md		25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.	
25C. FUNERAL DIRECTOR Joseph E. Elickson		ADDRESS 1129 N. Caroline			

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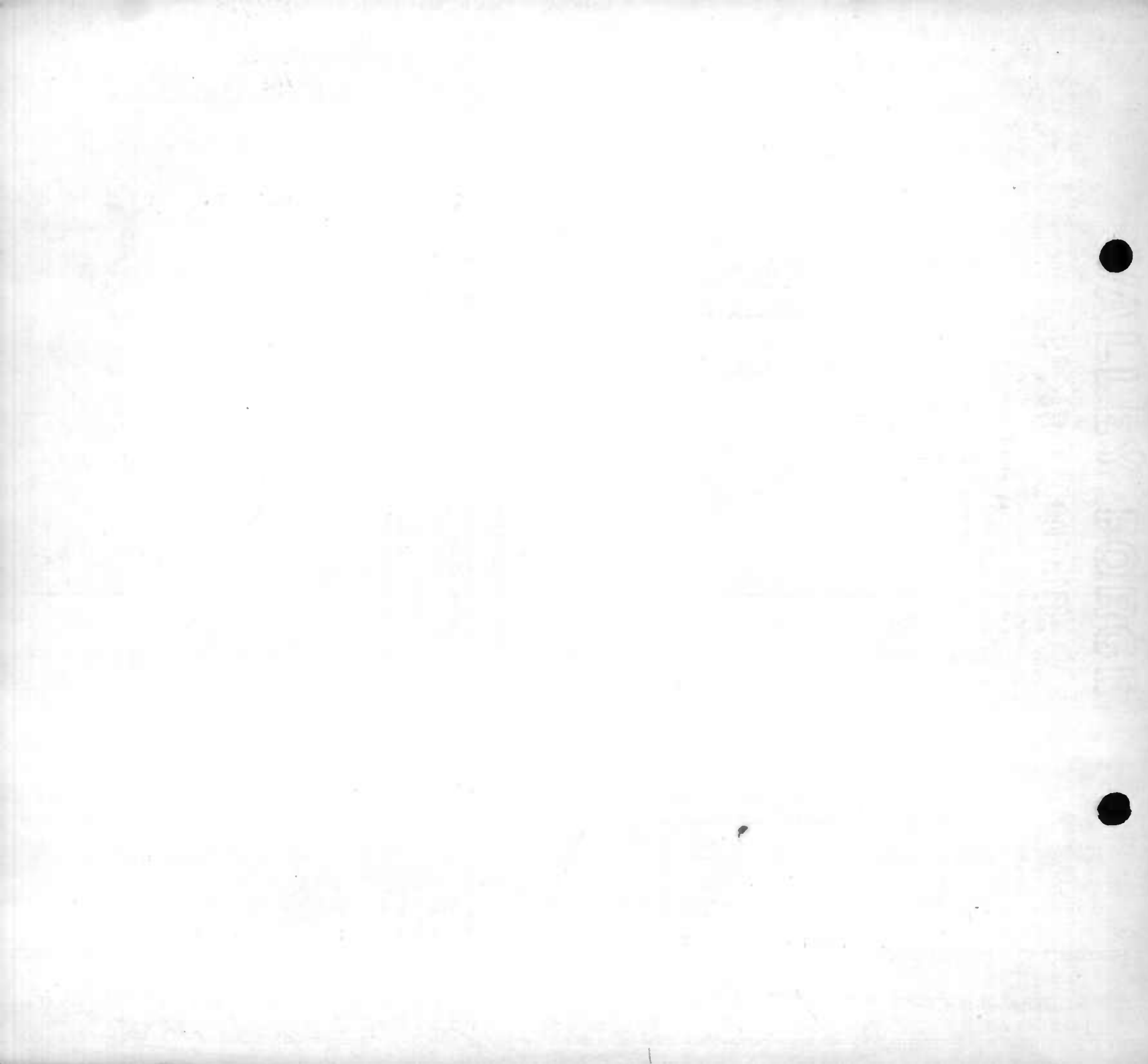
QUALITY CONTROL

QUALITY CONTROL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

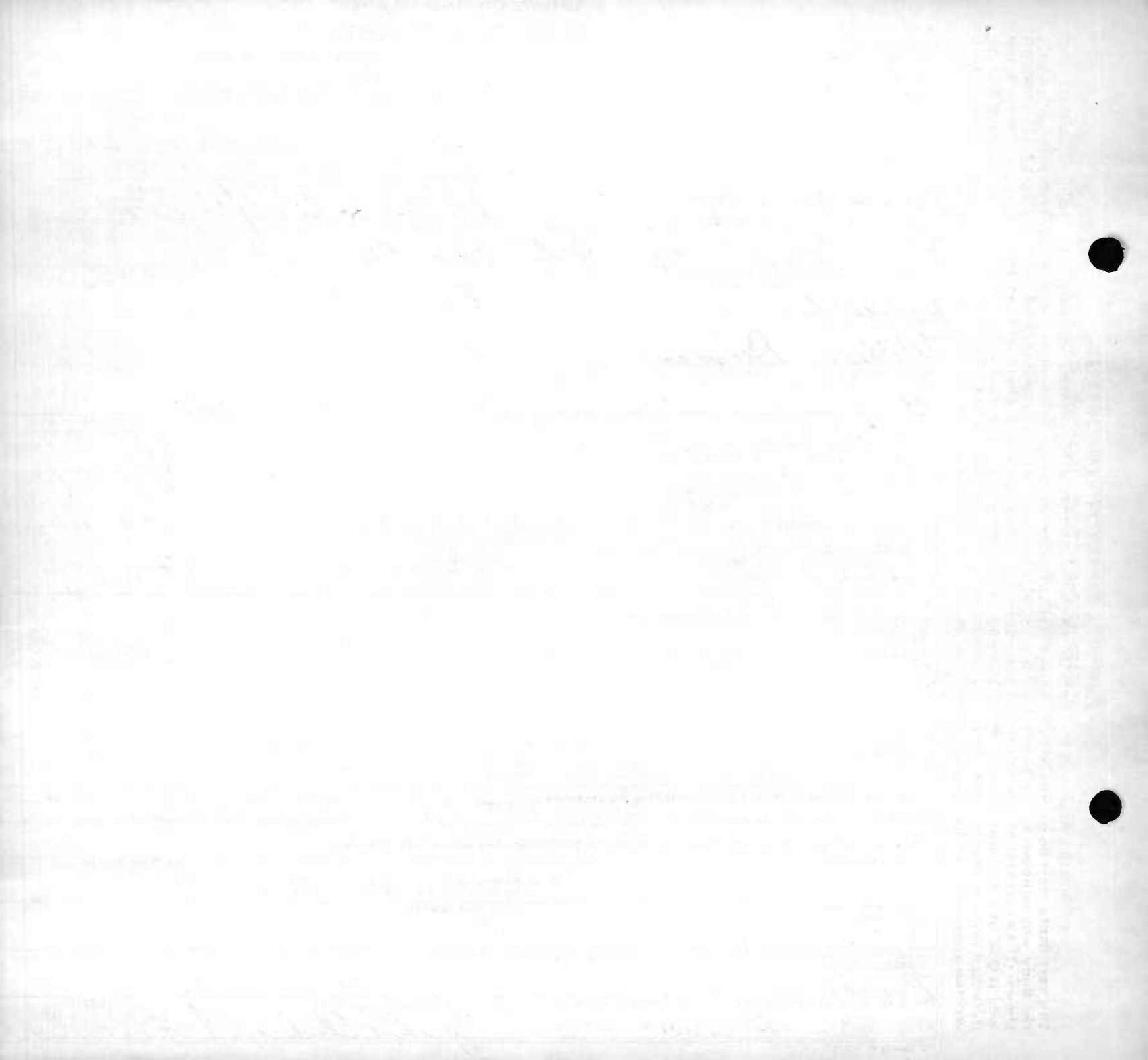
BIRTH NO. 65 6237				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 6237	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>(Martina)</i>		2. DATE AND HOUR OF DEATH <i>6/10/65 10:30 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>7-05</i>					
FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) <i>JOHNS HOPKINS HOSPITAL</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>		D. STREET ADDRESS (If rural, give location) <i>917 NORTH DALLAS ST.</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOW</i>	8. DATE OF BIRTH <i>1-27-09</i>	9. AGE (In years last birthday) <i>56</i>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Recreation Instructor</i>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>Baets Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>William Simone</i>			14. MOTHER'S MAIDEN NAME <i>Lulu</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Joan Rice 817 N Dallas St</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>331X1</i>			CAUSE OF DEATH (A) <i>intracerebral bleed 20</i> DUE TO (B) <i>hypertensive encephalop.</i> DUE TO (C) <i>longstanding hypertension 10-20 yrs</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <i>5/24</i> 19 <i>65</i> to <i>6/10</i> 19 <i>65</i> , that (1) (we) lost saw the deceased alive on <i>6/10</i> 19 <i>65</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) did (did not) view the body after death.									
23A. SIGNATURE <i>Wm Maddy</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/10</i>			
23C. PHYSICIAN'S NAME (Type) <i>DR. WILLIS MADDREY</i>				23D. ADDRESS M.D. <i>JOHNS HOPKINS HOSPITAL</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>June 14/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Calvary Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>A.A. County Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 16 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>		25C. FUNERAL DIRECTOR <i>Joseph T. Elickson</i>		ADDRESS <i>1129 N. Calhoun St</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6288				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6238	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Nileen May Beckham</i>				2. DATE AND HOUR OF DEATH <i>June 11/65 11:00 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>1535 N. Wolfe Street</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>md.</i>		B. COUNTY <i>8-06</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>1535 N. Wolfe Street</i>			
5. SEX <i>F</i>	6. RACE <i>Col.</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>Feb. 22, 1901</i>	9. AGE (In years last birthday) <i>64</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Bald. Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>William Duncan</i>				14. MOTHER'S MAIDEN NAME <i>Mary?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Phoebe Beckham</i>		ADDRESS <i>1535 N. Wolfe St</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>241X I</i>				CAUSE OF DEATH (A) DUE TO <i>Cerebral Apoplexy</i> (B) DUE TO <i>Hypertension</i> (C) DUE TO <i>Branchial Atherosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>2 years</i> <i>3 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>June 2</i> 19 <i>65</i> to <i>June 11</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>June 11</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Wm. L. Berry</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6-15-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Wm. L. BERRY</i>				23D. ADDRESS M.D. <i>1237 N. Caroline</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>June 16/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>A. A. County Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 15 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairley</i>		25C. FUNERAL DIRECTOR <i>Frank E. Elickson</i>		ADDRESS <i>129 N. Caroline</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6239				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6239	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CHARLES J. NOVASKA				2. DATE AND HOUR OF DEATH June 12, 1965 3:30 a. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2020 Hillenwood Road Baltimore, Md., 21214				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. - 21214 B. COUNTY 27-09 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2020 Hillenwood Road			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 4/2/1902	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) own business			10B. KIND OF BUSINESS OR INDUSTRY Market Basket Co.		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME unknown John G. Novaska			14. MOTHER'S MAIDEN NAME unknown Denisow				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 220-12-8705			16. SOCIAL SECURITY NO. 220-12-8705		17. INFORMANT ADDRESS Mary (nee May) Novaska, wife, above		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 287X1 Died in his sleep H.C.V. disease obesity & diabetes - about 30 yrs ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. as above				INTERVAL BETWEEN ONSET AND DEATH about 20 yrs			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1918 to June 12 - 1965 , that (I) (we) last saw the deceased alive on June 4 - 1963 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Herman Seidel M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>						23B. DATE SIGNED 6/14/65	
23C. PHYSICIAN'S NAME (Type) Dr. Herman Seidel		23D. ADDRESS M.D. 2404 Eutaw Place					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/15/65		24C. NAME OF CEMETERY or CREMATORY Balto. Nat. Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965		25B. NAME OF REGISTRAR Robert E. Talley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane			

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FUNERAL DIRECTOR: IMPORTANT

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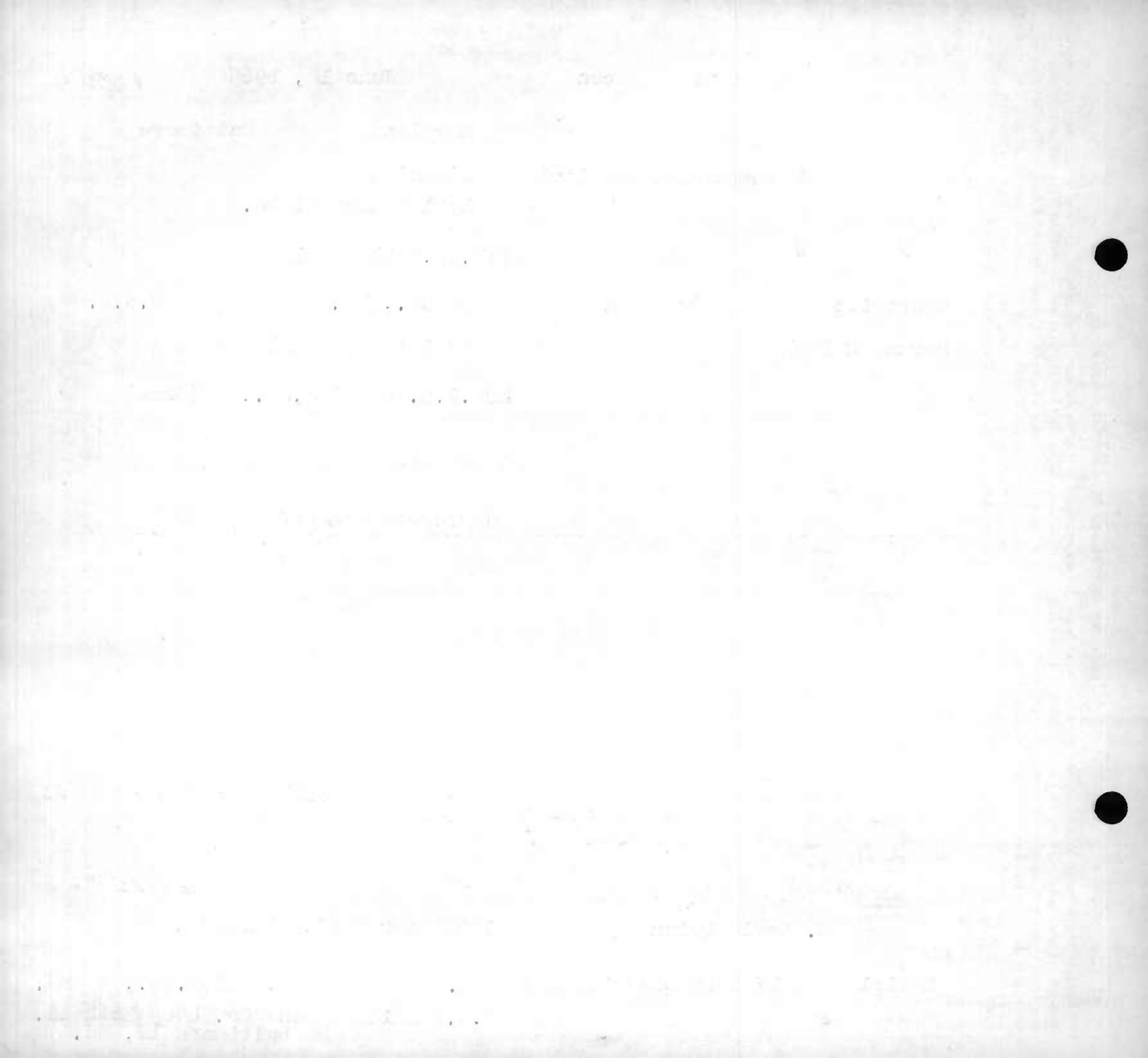
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6240	
BIRTH NO. 65 6240		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH June 15, 1965 1⁰⁰ A.M.	
1. NAME OF DECEASED (Type or Print) Maud Sindlinger Clark		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-13	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE CORRECTED 6-28-65 HILL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hill Crest Nursing Home		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 725 Gladstone Ave.	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1881 July 17, 1871
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 93 83
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Sindlinger		14. MOTHER'S MAIDEN NAME Amanda Best	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 337-38-5893	
17. INFORMANT Mrs. Harry P. Lavelle		ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1962 to June 15, 1965 , that (I) (we) last saw the deceased alive on June 14, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE William G. Helfrich		23B. DATE SIGNED 6-15-65	
23C. PHYSICIAN'S NAME (Type) William G. Helfrich		23D. ADDRESS 5006 Roland Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 6/15/1965	
24C. NAME OF CEMETERY or CREMATORY Green Mount		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965		25B. NAME OF REGISTRAR H.W. Jenkins & Sons Co.	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Baltimore 12, Md.	

Letter from Hillcrest Nursing Home
6-28-65 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6241	
BIRTH NO. 65 6241		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Caroline Bacon		2. DATE AND HOUR OF DEATH June 14, 1965 1:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		A. STATE Maryland 8. COUNTY Baltimore			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Timonium			
		D. STREET ADDRESS (If rural, give location) 1721 Lynncrest Rd.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Feb. 23, 1874	9. AGE (In years last birthday) 91	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Herman Muinch			
14. MOTHER'S MAIDEN NAME Louise Ladidenslager		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. J.M. Shinnick, Jr., (Same)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I Coronary Thrombosis		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO arteriosclerosis			
(B) DUE TO		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-21-1962 to 6-14-1965 ; that (I) was lost saw the deceased alive on 5/27/1965 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.					
23A. SIGNATURE M. Kevin Quinn				23B. DATE SIGNED 6-15-65	
23C. PHYSICIAN'S NAME (Type) M. Kevin Quinn				23D. ADDRESS 1927 York Road, Timonium, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/17/1965		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cem.	
24D. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.			



BIRTH NO.

65

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LEON JOE RYNARZEWSKI

2. DATE AND HOUR PRONOUNCED DEAD

6-13-65

8:32 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
MarylandB. COUNTY
Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1410 Old Eastern Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec. 23, 1922

9. AGE (In years
last birthday)

44 42

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

Home Decorating

11. BIRTHPLACE (State or foreign country)

Severn, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Rynarzewski

14. MOTHER'S MAIDEN NAME

Agnes Kamosa

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WWII

16. SOCIAL
SECURITY NO.

214-12-8587

17. INFORMANT

Sophie K. Rynarzewski

ADDRESS

6707 Thruway
Baltimore 22

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

with coronary occlusion

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-14-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/16/65

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 15 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Walter Brooks Bradley, Inc., Dundalk

ADDRESS

WALTER FORGER

Proctor

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Harriet Henderson

2. DATE AND HOUR PRONOUNCED DEAD

June 12, 1965

5:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

ANNE ARUNDEL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Glen Burnie

D. STREET ADDRESS (If rural, give location)

116 Dorchester Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept. 21, 1910

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Home Maker

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Washington, DC

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

(UNKNOWN) Poole

14. MOTHER'S MAIDEN NAME

Zita (UNKNOWN)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

NO

XX

16. SOCIAL
SECURITY NO.

578/03/8952

17. INFORMANT

Charles E. Henderson

ADDRESS

Same As #4

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

hospital

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

University Hospital, Baltimore

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

June 12, 1965 4:00A

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

X

21F. HOW DID INJURY OCCUR?

fell from 10th floor of hospital

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 12, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

June 15, 1965

23C. NAME of CEMETERY or CREMATORY

National Mem. Park

23D. LOCATION

(City, town, or county)

(State)

Falls Church Va.

24A. DATE REC'D BY HEALTH DEPT.

JUN 15 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

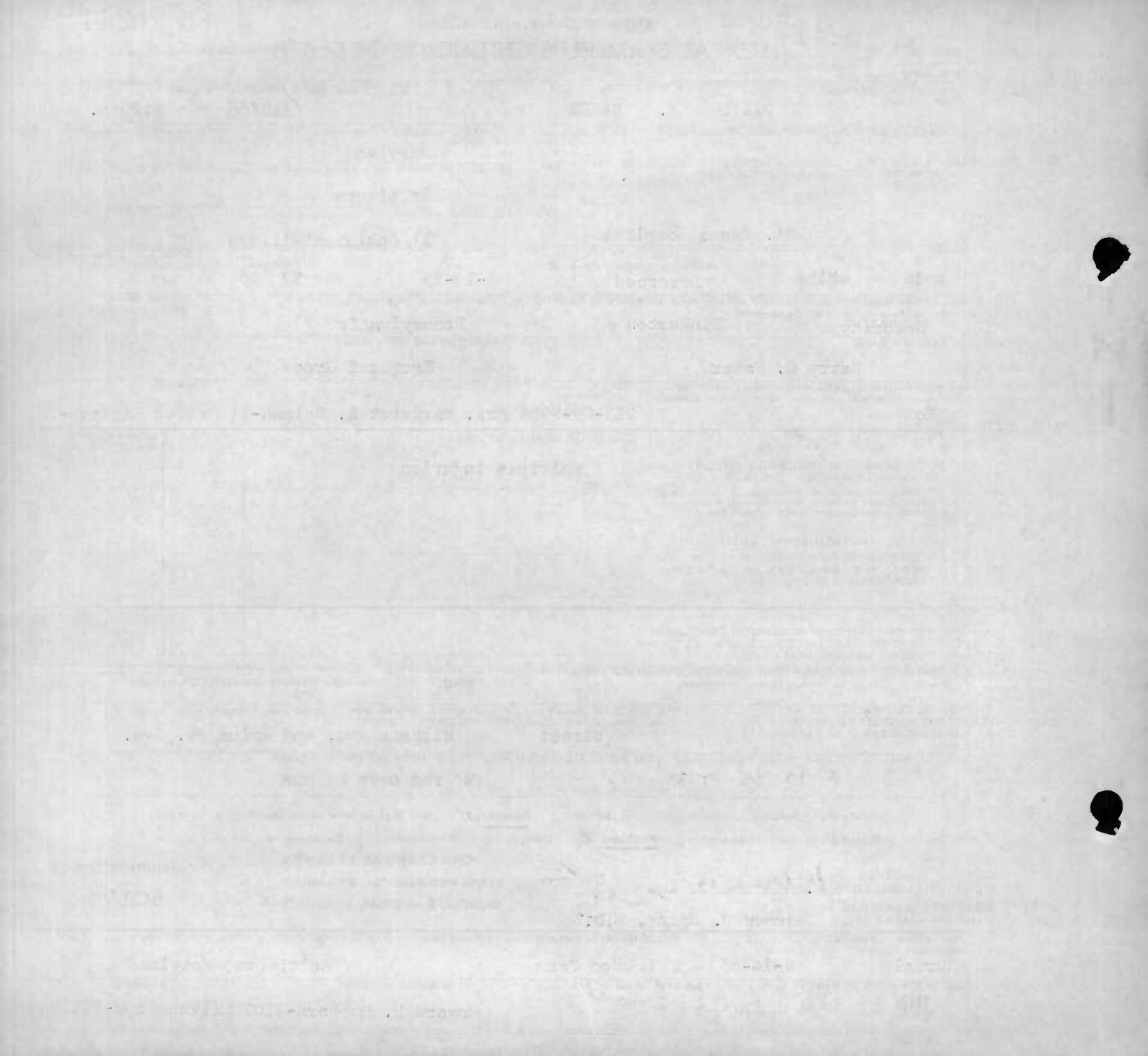
24C. FUNERAL DIRECTOR

R.V. SINGLETON GLEN BURNIE, MD.

ADDRESS

WALLLEY FOLIOLE

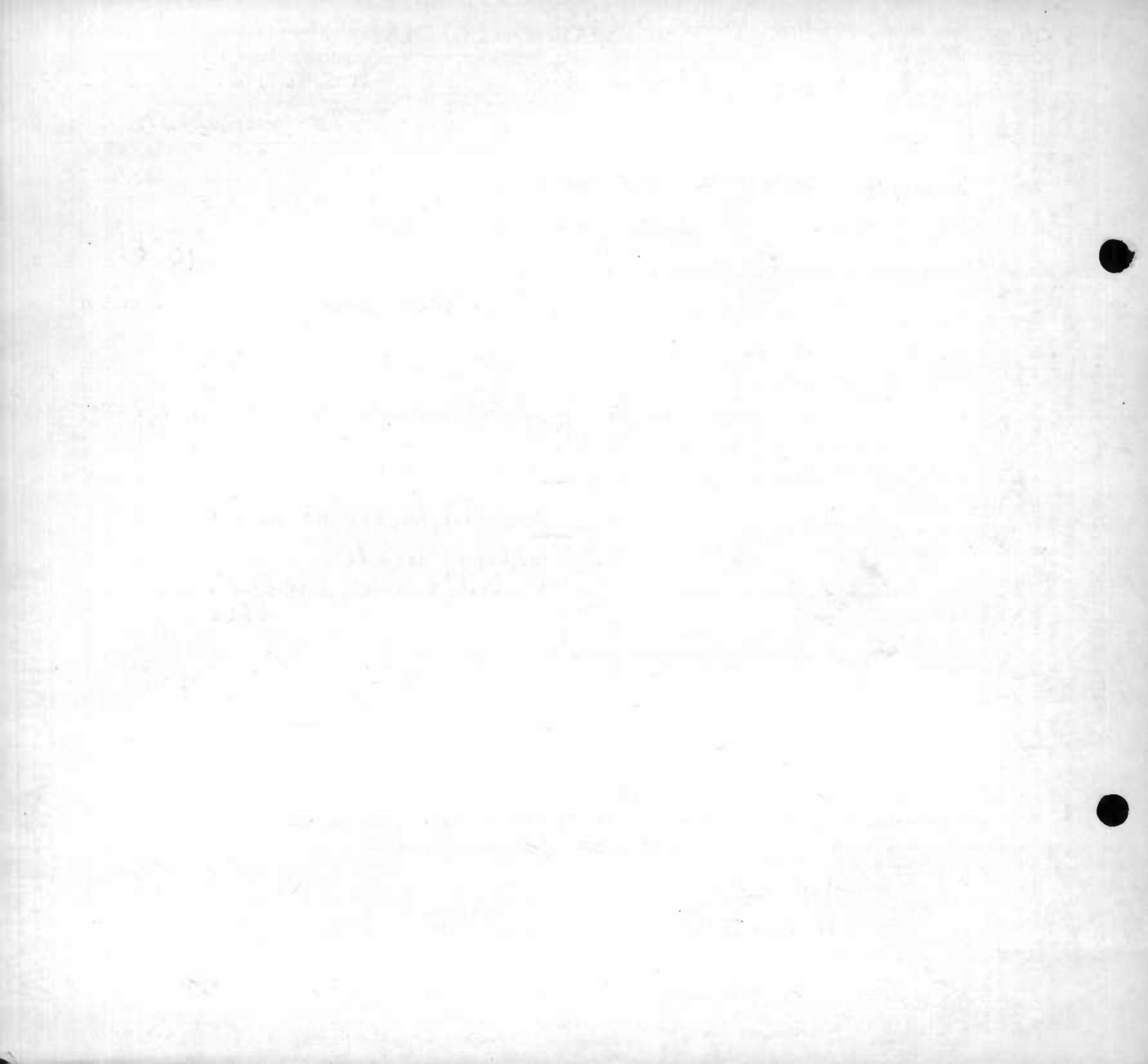
BIRTH NO. 65 6244		BALTIMORE CITY HEALTH DEPARTMENT		65 6244	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No. _____	
1. NAME OF DECEASED (Type or Print) DALTON E. BAKER				2. DATE AND HOUR PRONOUNCED DEAD 6/10/65 9:20 p.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD St. Agnes Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
				D. STREET ADDRESS (If rural, give location) 11 Oakleigh Village	
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 1-12-15	9. AGE (In years last birthday) 50	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Security		10B. KIND OF BUSINESS OR INDUSTRY Pinkerton		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Harry C. Baker			14. MOTHER'S MAIDEN NAME Margaret Green		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-9966		17. INFORMANT ADDRESS Mrs. Margaret A. Salmon-11 Oaklee Villate-29	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Multiple injuries (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6/10/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Wilkins Ave. and Arion Pk. Ave.					
21D. TIME OF INJURY (APPROX.) 6 10 65 9:03p		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? run over by bus	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				DATE SIGNED 6/11/65	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6-14-65		23C. NAME of CEMETERY or CREMATORY Loudon Park	
24A. DATE REC'D BY HEALTH DEPT. JUN 15 1965		24B. NAME OF REGISTRAR Robert E. Taylor		24C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard-4107 Wilkins Ave-21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

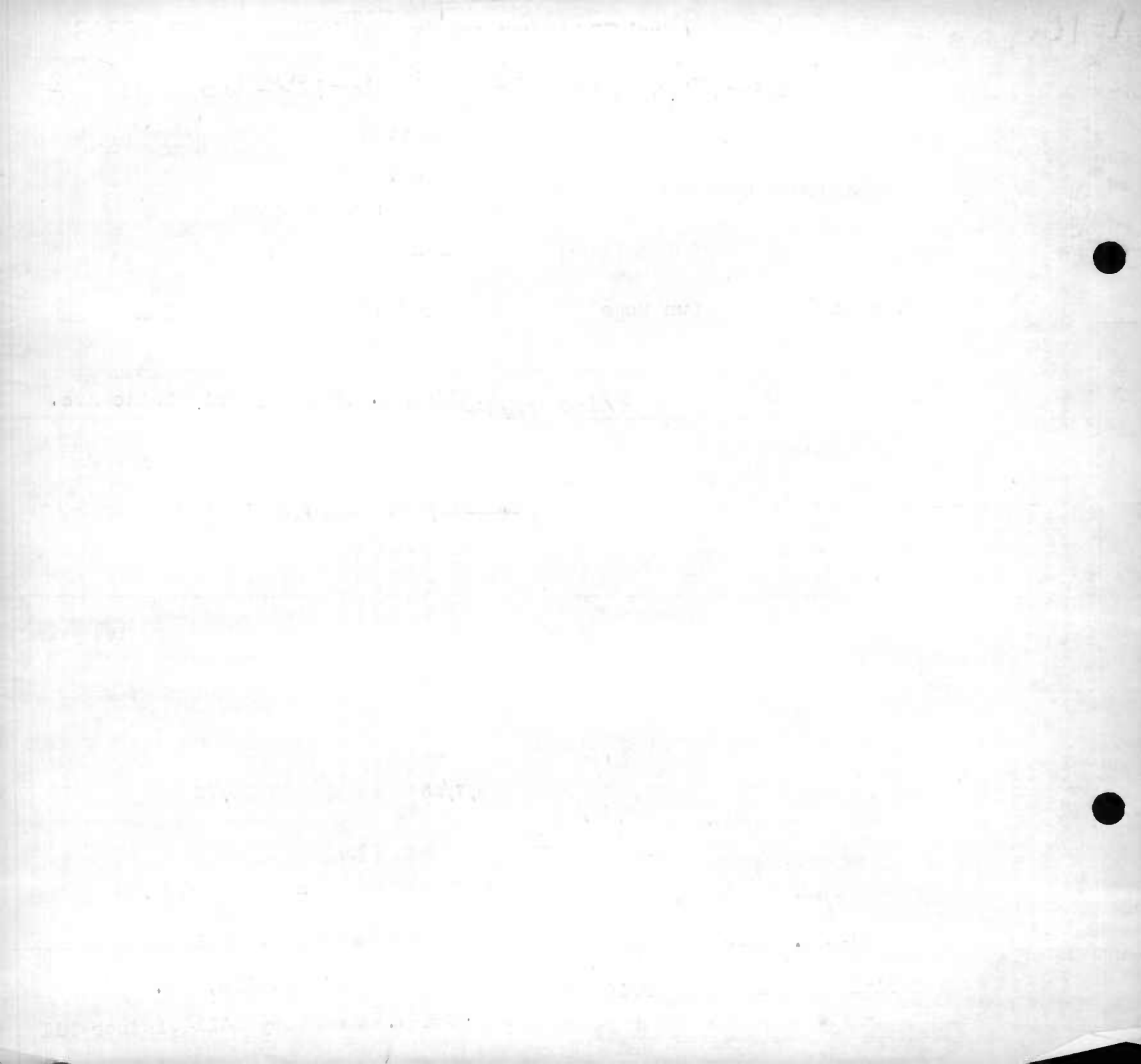
BIRTH NO. <u>64-19323 65 6245</u>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. <u>65 6245</u>	
1. NAME OF DECEASED (Type or Print) <u>KEYSER, KRISTIN ANN</u>				2. DATE AND HOUR OF DEATH <u>11 JUNE 1965</u> <u>2:52 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNION MEMORIAL HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>33-00</u> D. STREET ADDRESS (If rural, give location) <u>8619 HOERNER AVE</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>N.M.</u>	8. DATE OF BIRTH <u>19 JULY 1964</u>	9. AGE (In years last birthday) <u>10:22</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(EDWARD) KEYSER</u>				14. MOTHER'S MAIDEN NAME <u>PATRICIA ANN KING</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>EDWARD L. KEYSER, JR.</u>		ADDRESS <u>8619 HOERNER AVE</u>	
18. <u>410X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19. MEDICAL CERTIFICATION CERTIFICATION APPROVED BY <u>[Signature]</u> CHIEF MEDICAL EXAMINER		CAUSE OF DEATH <u>myocarditis and endocarditis, involving mitral valves, acute, cerebral edema, moderate ARB</u>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>—</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>11 JUNE 1965</u> to <u>11 JUNE 1965</u> , that (1) (we) last saw the deceased alive on <u>11 JUNE 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11 JUNE 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>H. BRENNER</u>				23D. ADDRESS M.D. <u>Union Memorial Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/14/65</u>		24C. NAME of CEMETERY or CREMATORY <u>LAKE VIEW MEMORIAL</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Mo.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 15 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>8521 Loch Raven Blvd</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 6246					Registered No. 65 6246				
BIRTH NO. 65 6246									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <u>Pape, Marguerite</u>					2. DATE AND HOUR OF DEATH <u>6-12-65 11:30 A.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>10-02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>848 HILLMAN COURT</u>				
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED <u>NEVER MARRIED</u>		8. DATE OF BIRTH <u>9-2-93</u>	9. AGE (In years lost birth) <u>71</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>CHARLES PAPE</u>					14. MOTHER'S MAIDEN NAME <u>MARY WEST</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>293-12-3533</u>		17. INFORMANT <u>William W. Pape 205 Brightside Ave.</u>				
18. <u>200.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Hypercalcemia</u> (A) DUE TO <u>Reticulum cell sarcoma</u> (B) DUE TO (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH <u>Hypercalcemia</u> <u>Reticulum cell sarcoma</u> <u>two weeks</u> <u>7 weeks</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>ASCVD</u>					INTERVAL BETWEEN ONSET AND DEATH <u>two years</u>				
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <u>6245</u> (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>6/7/65</u> 19 <u>65</u> to <u>6/12</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>6/12/65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Gino V. Segre</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>6/12/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Gino V. Segre</u>					23D. ADDRESS M.D. <u>Johns Hopkins Hospital</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/15/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 15 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>John T. Stansbury 6411 Windsor Mill</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 6247		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6247	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) BURRIS, MARY			
2. DATE AND HOUR OF DEATH 6-11-1965 7:30 A.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-04				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) 206 E. 20th St.				5. SEX Female 6. RACE Cau 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed			
8. DATE OF BIRTH 8/13/79		9. AGE (In years last birthday) 85		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Harford County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William F. Ely	
14. MOTHER'S MAIDEN NAME Mary E. Ball		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Madeline Conway Cocksackie, N.Y.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 5-6 days		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ATHEROSCLEROTIC CARDIOVASC. DISEASE		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
21A. DATE OF OPERATION 0		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 6-7-1965 to 6-11-1965 that (I) (we) last saw the deceased alive on 6-11-1965 and that in (my) (our) opinion death occurred on the day and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE Joseph Notarangelo M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23B. DATE SIGNED 6-11-1965		23C. PHYSICIAN'S NAME (Type) JOSEPH NOTARANGELO M.D.		23D. ADDRESS MERCY HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 6/14/65		24C. NAME OF CEMETERY or CREMATORY Forest Oak Cemetery		24D. LOCATION (City, town, or county) (State) Gathersburg, Mont.Co. Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965	
25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc		ADDRESS 1217 St. Paul St. Baltimore Md 21202		VS 150-REV. 1/1/65	

6-11-1962

6-11-1962

WEEK 4-25-1962

6-11-1962

WEEK 4-25-1962

6-11-1962

6-11-1962

Joseph H. H. H.

Joseph H. H. H.

WEEK 4-25-1962

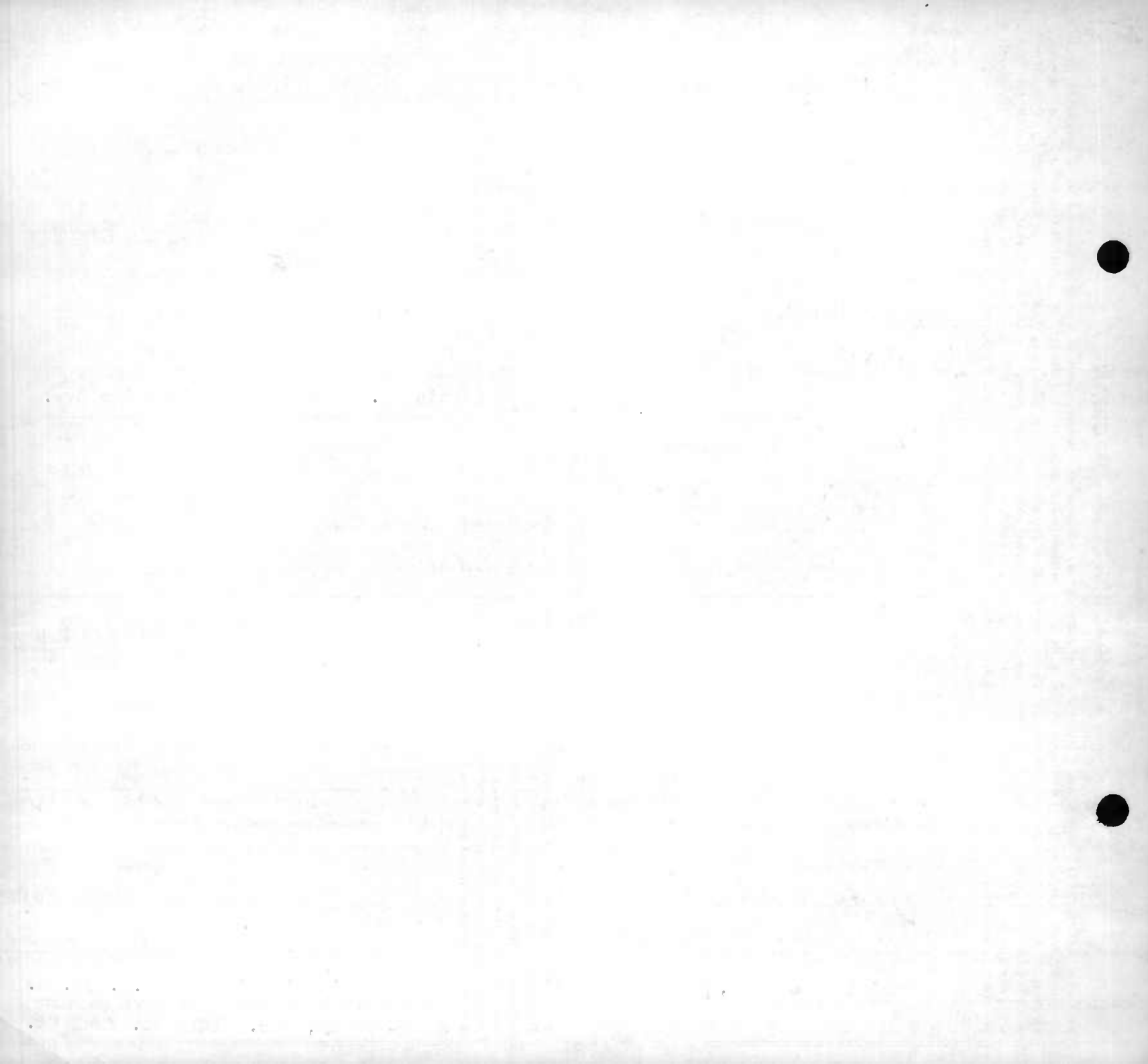
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6-11-1962

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6248		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 6248	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PATRICIA ANN BOYD		2. DATE AND HOUR OF DEATH JUNE 12, 1965 12 45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 24-02			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 30			
		D. STREET ADDRESS (If rural, give location) 1253 RIVERSIDE AVENUE			
5. SEX Fe.	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-19-40	9. AGE (In years lost birthday) 25	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME William H. Burr		14. MOTHER'S MAIDEN NAME ROSA LEE GODLEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 220-36-7986		17. INFORMANT ADDRESS Johnie B. Boyd 1253 Riverside Ave.	
18. 410X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Heart Failure, acute		CAUSE OF DEATH (A) DUE TO Coronary Heart Failure, acute (B) DUE TO Rheumatic Heart Disease w/ (C) DUE TO Mitral Stenosis		INTERVAL BETWEEN ONSET AND DEATH 11 hrs. years 18 1/2 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute delivery					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 11 19 65 to June 12 19 65 , that (I) (we) last saw the deceased alive on June 12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Denaida C. Palad		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 12, 1965	
23C. PHYSICIAN'S NAME (Type) DENIDA C. PALAD		23D. ADDRESS BON SECOURS HOSP. BALTO. 23 Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 15, 65		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Ritchie Highway A.A. Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Wm Cook-Brooks, Inc. 1217 St. Paul St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6249	
BIRTH NO. 65 6249		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BURNS HENRY R.		2. DATE AND HOUR OF DEATH 6/12/65 17 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 13-08			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL 827 LINDEN AVE. BALTO 11, MD.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 1326 UNION AVE.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/2/77	9. AGE (In years last birthday) 87	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY TEXTILE WORKER		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME WILLIAM BURNS		14. MOTHER'S MAIDEN NAME MARY MELVIN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 213-12-8513		17. INFORMANT ADDRESS MARYLAND GEN. HOSP. 827 LINDEN AVE	
18. 493 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA		(A) DUE TO		(B) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/28 19 65 to 6/12 19 65 , that (I) (we) lost saw the deceased alive on 6/12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Pietro Lost man				23B. DATE SIGNED 6/12/65	
23C. PHYSICIAN'S NAME (Type) LASTRUCCI PIETRO		23D. ADDRESS MARYLAND GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/15/65		24C. NAME OF CEMETERY or CREMATORY Woodlawn	
24D. LOCATION Balto Co.		24E. CITY, TOWN, or county		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Paul E. Chenoweth	
		25D. ADDRESS 3617 Chestnut Ave.			

TEXAS WOMEN

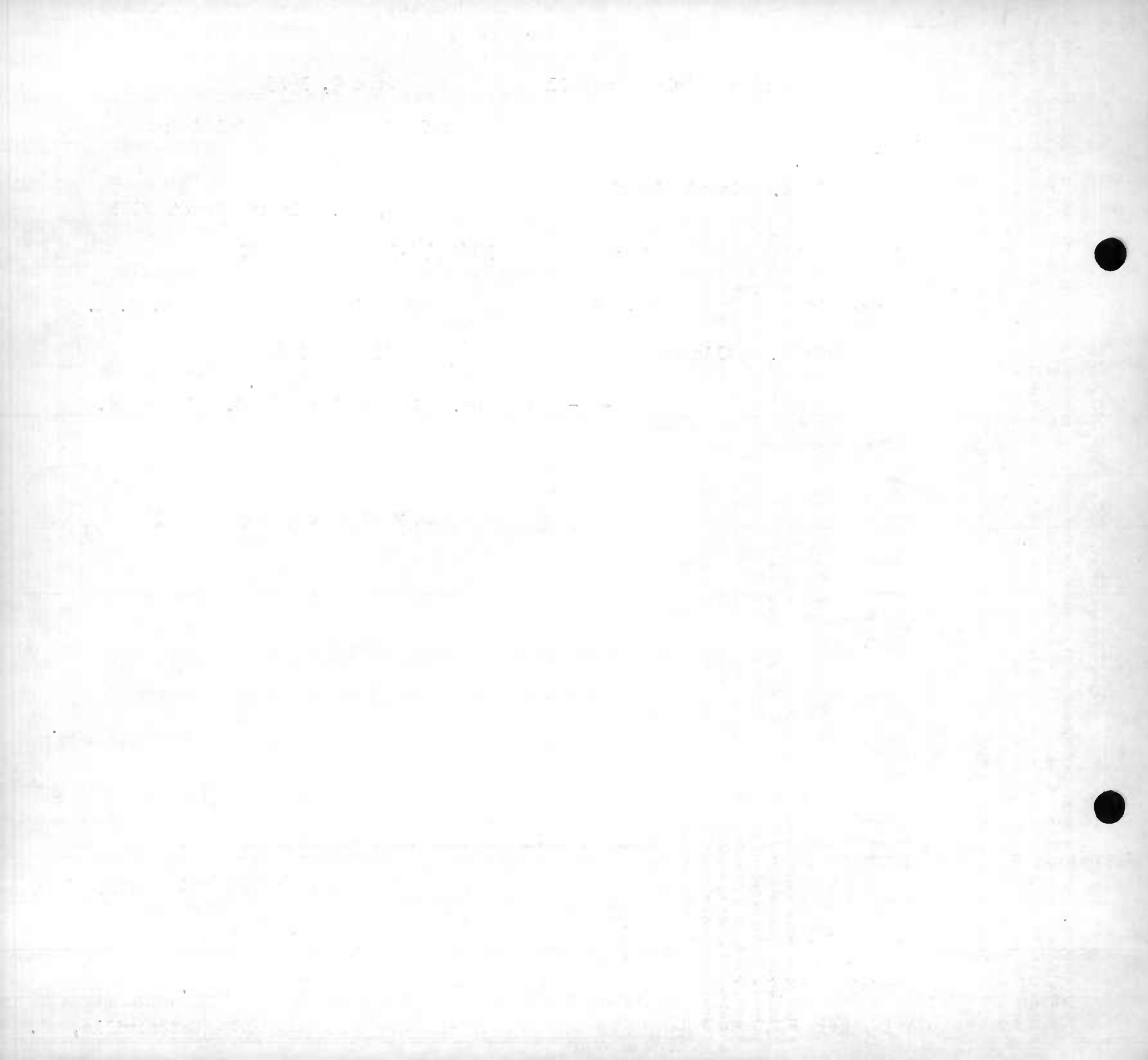
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6/10/13

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

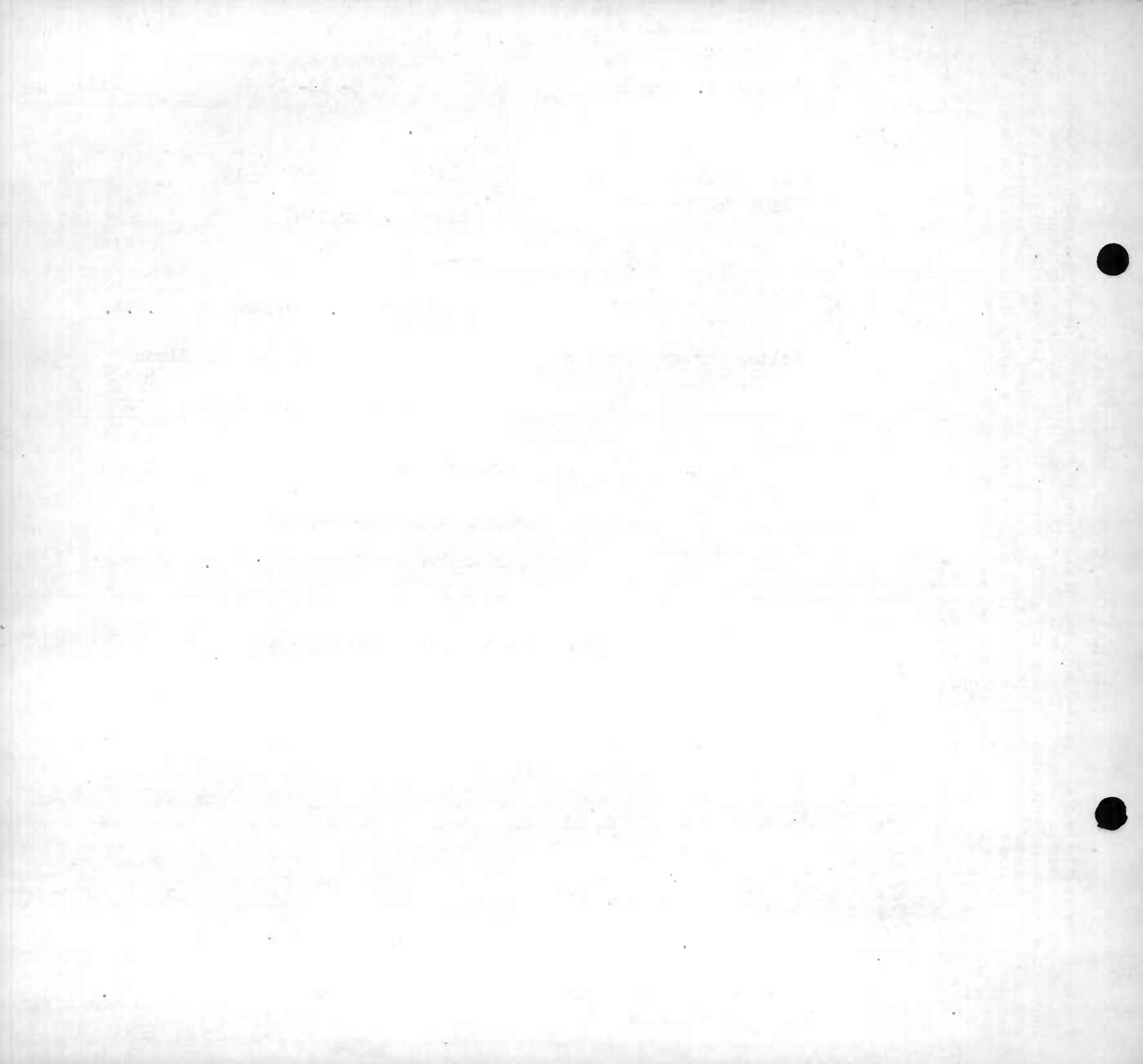
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6250	
BIRTH NO. 65 6250		CERTIFICATE OF DEATH		M. 65 6250	
1. NAME OF DECEASED (Type or Print) Bertha Viola Scannell			2. DATE AND HOUR OF DEATH June 9, 1965		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2930 N. Calvert Street			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2930 N. Calvert Street 21218		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 10/29/1893	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John O. Bollinger			14. MOTHER'S MAIDEN NAME Ella Baublitz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-48-0852	17. INFORMANT Baltimore, Md. 21218 Mrs. Lulu Hopkins 2930 N. Calvert St.		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 4-10-11 CAUSE OF DEATH (A) <u>Coronary thrombosis</u> DUE TO (B) <u>A-S Heart disease</u> DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>5 yrs.</u>					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) <u>(at hospital)</u> attended the deceased from <u>June 1963</u> to <u>June 11, 1965</u> . that (I) <u>was</u> last saw the deceased alive on <u>May 18, 1965</u> and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>N.R. Freeman, Jr.</u>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6/11/65</u>
23C. PHYSICIAN'S NAME (Type) <u>N.R. Freeman, Jr.</u>			23D. ADDRESS <u>11 W. 24th St.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/14/1965	24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965		25B. NAME OF REGISTRAR <u>Robert E. Fickens</u>		25C. FUNERAL DIRECTOR <u>Easton Funeral Home</u>	
ADDRESS Catonsville, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

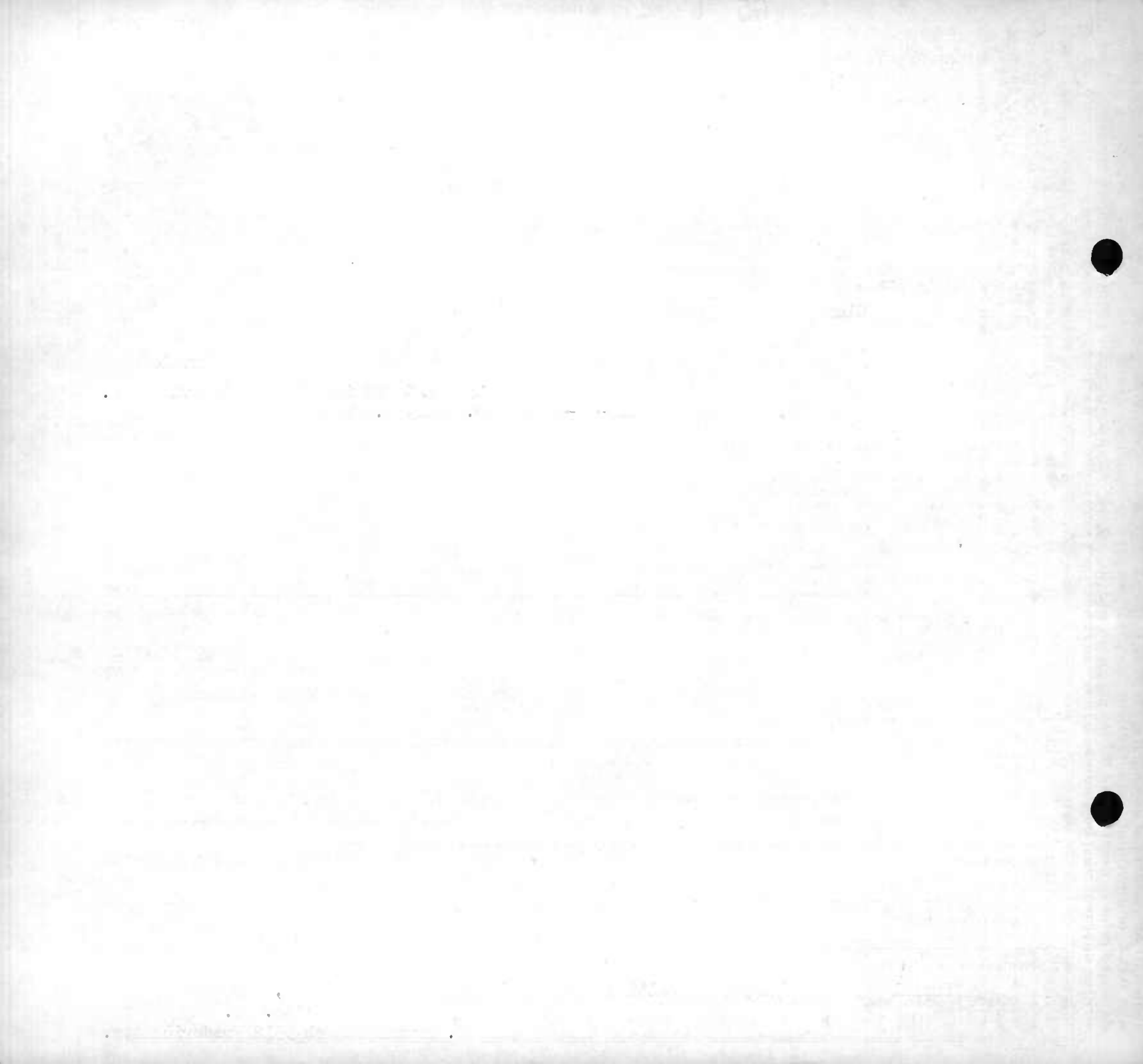
BIRTH NO. 65 6251				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6251	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Myrtle V. Reynolds				2. DATE AND HOUR OF DEATH 6-12-1965 1:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould Convelesent Home 6106 Belair Road				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore (Rural) D. STREET ADDRESS (If rural, give location) Glyndon, Maryland			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 5-9-1890	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Baltimore Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Shelton Harvey Reynolds				14. MOTHER'S MAIDEN NAME Willie Ann Wilson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Charles Breidenbaugh Fork Road			ADDRESS 21051 2
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) A Cerebral Thrombosis DUE TO		2 Days	
				(B) Cerebral Arteriosclerosis DUE TO		3 years	
				(C) Hypertensive cardiovascular dis.		10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cholecystitis (Chr) Uterinetibroids							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov 8, 1956 to June 12, 1965 , that (I) (we) lost saw the deceased alive on 6, 11, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Clifford F. Hudson M.D.				23B. DATE SIGNED 6/12/65			
23C. PHYSICIAN'S NAME (Type) Dr Clifford F. Hudson M.D.				23D. ADDRESS Fork Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6-14-1965	24C. NAME of CEMETERY or CREMATORY Fork Christian Cemetery		24D. LOCATION (City, town, or county) (State) Fork, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 741 Belair Road			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

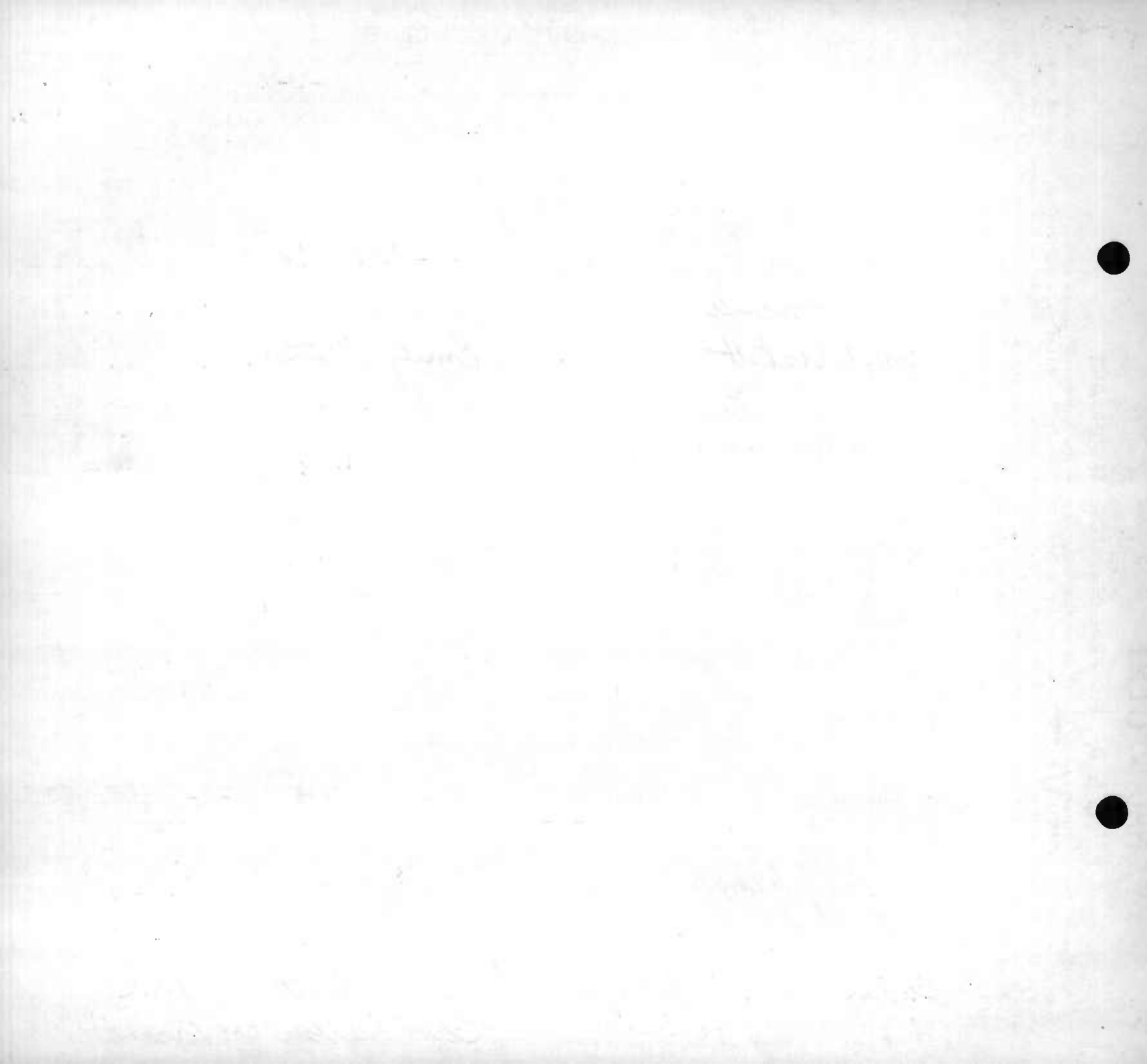
BIRTH NO. 65 6252				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6252	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Pauline Gross</u>				2. DATE AND HOUR OF DEATH <u>June 13, 1965</u> <u>1:45 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u>				A. STATE <u>Maryland</u> B. COUNTY <u>28-04</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>250 E. Medwick Garth</u>			
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 10, 1906</u>	9. AGE (In years last birthday) <u>58</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Bank</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick Zackman Sackmann</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Myrtle Merkle</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-05-1119</u>		17. INFORMANT ADDRESS <u>250 East Medwick Garth Catonsville Md.</u> <u>Mr. Henry C. Gross</u>	
18. <u>153.8 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic Adenocarcinoma of Colon</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>March 20</u> 19 <u>65</u> to <u>June 13</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>June 13</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Larry S. Tilley</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>June 13, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>L. G. Tilley</u>				23D. ADDRESS M.D. <u>Maryland General Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/16/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 15 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>G. Truman Schwab</u>		ADDRESS <u>3512 Frederick Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

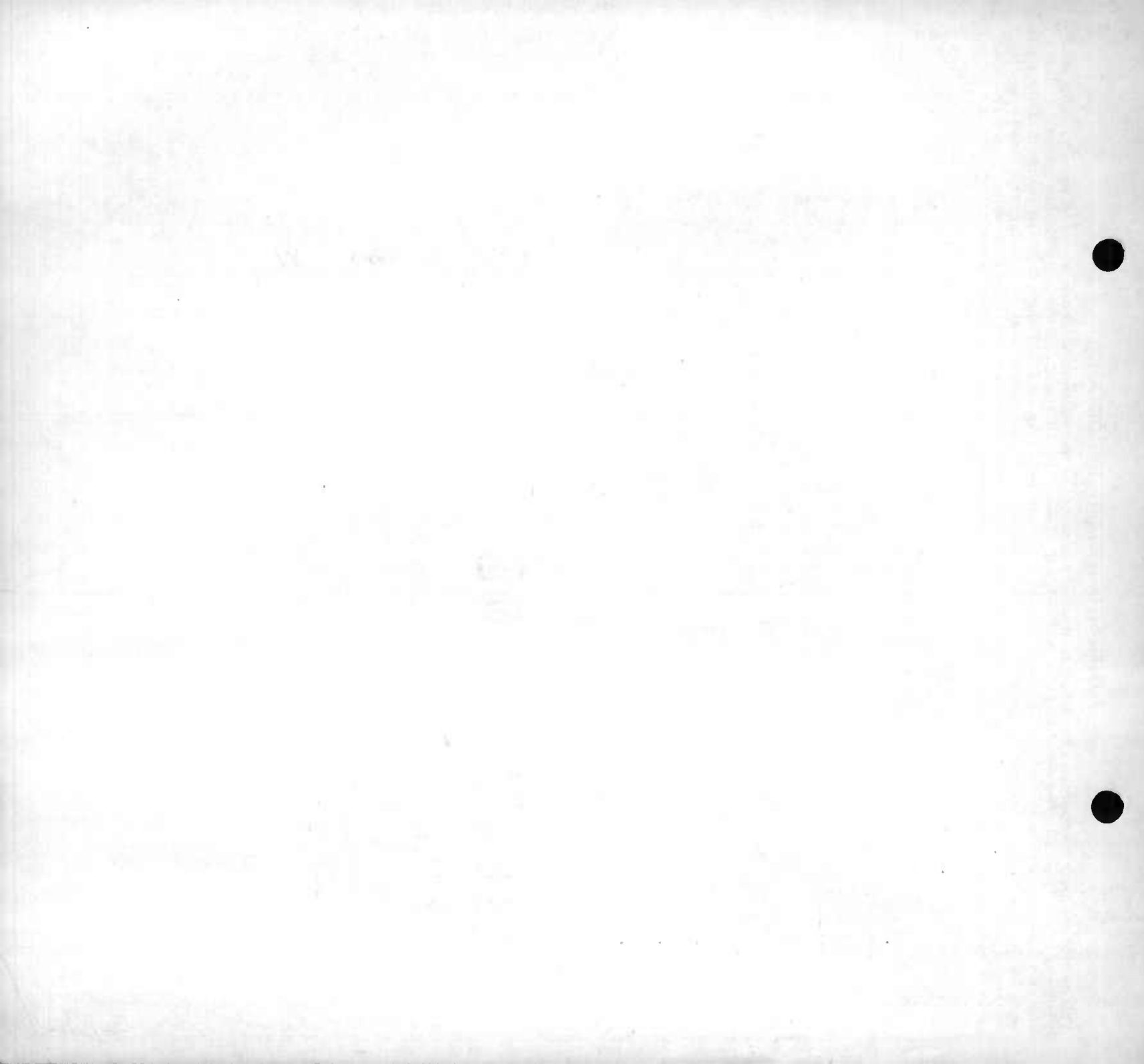
BIRTH NO. 65 6253		CERTIFICATE OF DEATH 65 6253		Registered No. 65 6253	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Maude Smith			2. DATE AND HOUR OF DEATH 6-13-65 6:05 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 928 Ridgley Street #21230		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 3-15-1899	9. AGE (In years last birthday) 66	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Joseph Crockett			14. MOTHER'S MAIDEN NAME Emily Mitchell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, or unknown) (If yes, give war or dates of service) No.			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS RECORDS: B.C.H. 4940 Eastern Avenue #21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Metastatic Carcinoma of Cervix DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 2 Years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work Not While At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-3-1965 to 6-13-1965 that (I) (we) last saw the deceased alive on 6-13-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Charles Carpenter M.D.				23B. DATE SIGNED 6-13-65	
23C. PHYSICIAN'S NAME (Type) Dr. Charles Carpenter M.D.				23D. ADDRESS 4940 Eastern Avenue #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/15/65		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem	
24D. LOCATION Balto		24E. (City, town, or county) Mel		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Choy W. Wilson 1001 Brantley St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

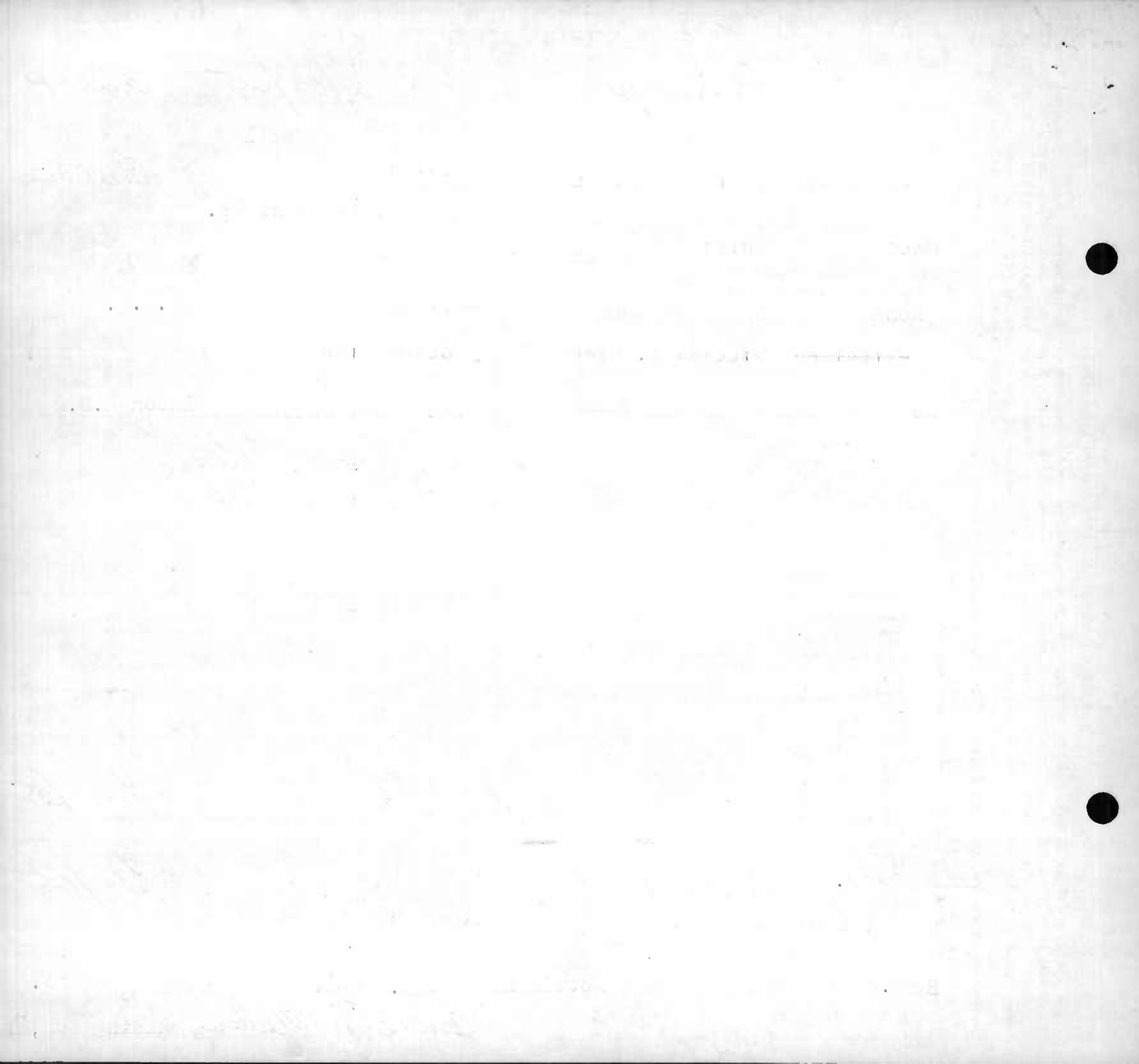
B-160		65 6254		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6254	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Sallie Brown Beaver</i>				2. DATE AND HOUR OF DEATH <i>6-8-65 11:15 AM</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Home - 632 Arlington Ave.</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>16-01</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>632 N. Arlington Ave.</i>			
5. SEX <i>Female</i>	6. RACE <i>Colored</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>Dec 25, 1893</i>	9. AGE (In years lost birthday) <i>81</i>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Green Co. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>James Mc Greder</i>				14. MOTHER'S MAIDEN NAME <i>Lucy Mack</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) CAUSE OF DEATH <i>Cerebral Hemorrhage</i> DUE TO (B) <i>He U</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>14 hrs.</i> <i>3 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>6/7</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>4/11/62</i> 19 <i>61</i> to <i>6/8</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>6/7</i> 19 <i>61</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>J. Preston Grant</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>6/15/65</i>			
23C. PHYSICIAN'S NAME (Type) <i>J. Preston Grant, M. D.</i>				23D. ADDRESS <i>601 N. Carrollton</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-11-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Arbutus Mem. Park</i>		24D. LOCATION (City, town, or county) (State) <i>Arbutus Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 15 1985</i>		25B. NAME OF REGISTRAR <i>Robert E. Fink</i>		25C. FUNERAL DIRECTOR <i>S. J. Wilson</i>		ADDRESS <i>1000 Brantly Ave</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

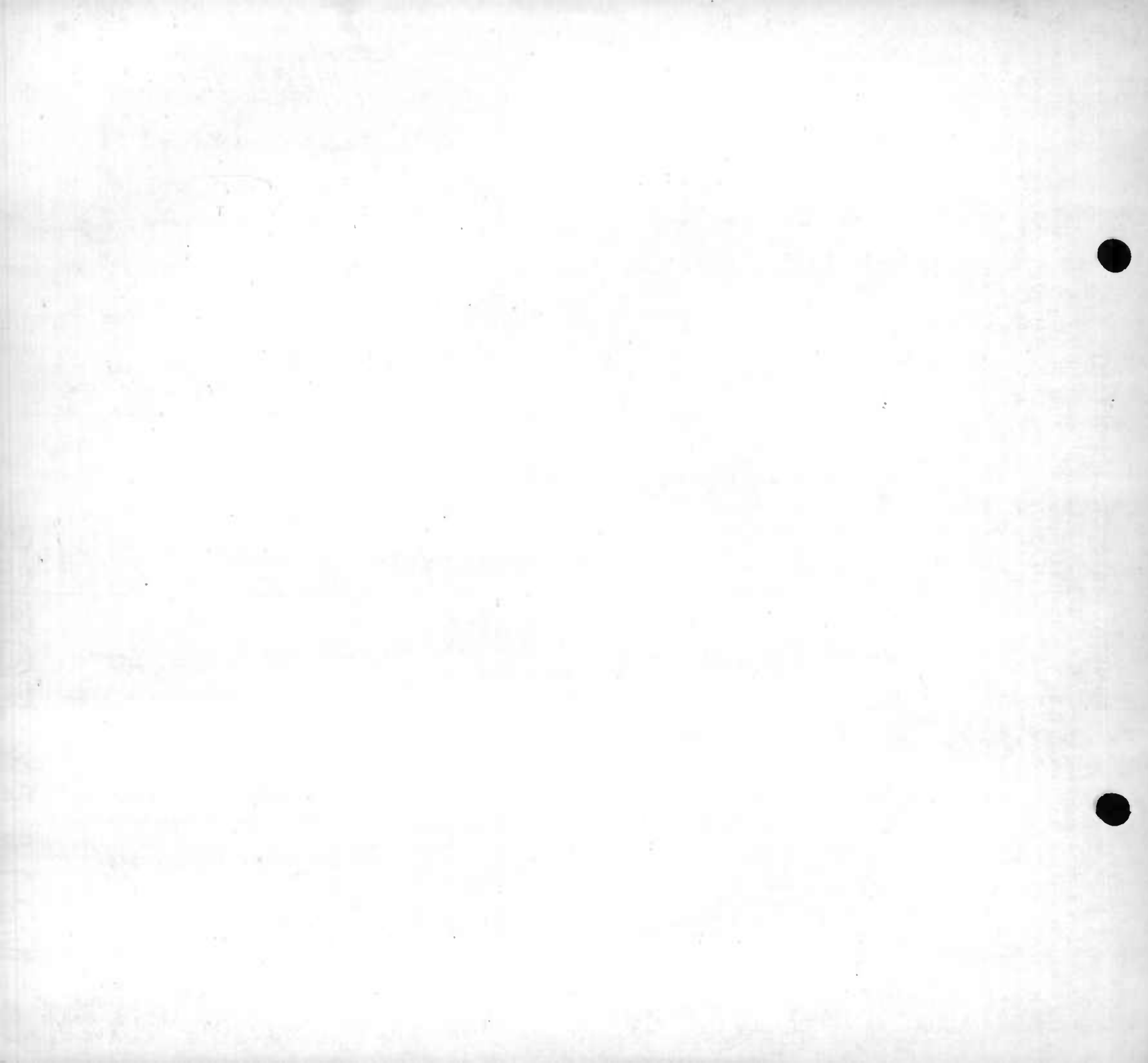
BIRTH NO. 65 6255				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6255	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>David Kemp</i>				2. DATE AND HOUR OF DEATH <i>6/10/65 3:20 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				A. STATE MARYLAND B. COUNTY Cecil			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELKTON 57-00 RURAL			
				D. STREET ADDRESS (If rural, give location) R D 2 CHESAPEAKE RD.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED SINGLE	8. DATE OF BIRTH 5-3-65		9. AGE (In years last birthday) 1 7	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME -WILLARD E. KEMP				14. MOTHER'S MAIDEN NAME CLARA MIMM			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Clara Mimm Kemp Elkton R.D.2	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CONGENITAL HEART DISEASE ASD, VSD, PDA				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6/10/65</i> to <i>6/10/65</i> that (I) (we) last saw the deceased alive on <i>6/10/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Louise Linarelli</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/10/65</i>	
23C. PHYSICIAN'S NAME (Type) LOUISE LINARELLI				23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>6/13/65</i>		24C. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.		24D. LOCATION (City, town, or county) (State) Colora Cecil Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>Thomas M. Mullen</i>		ADDRESS Rising Sun, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

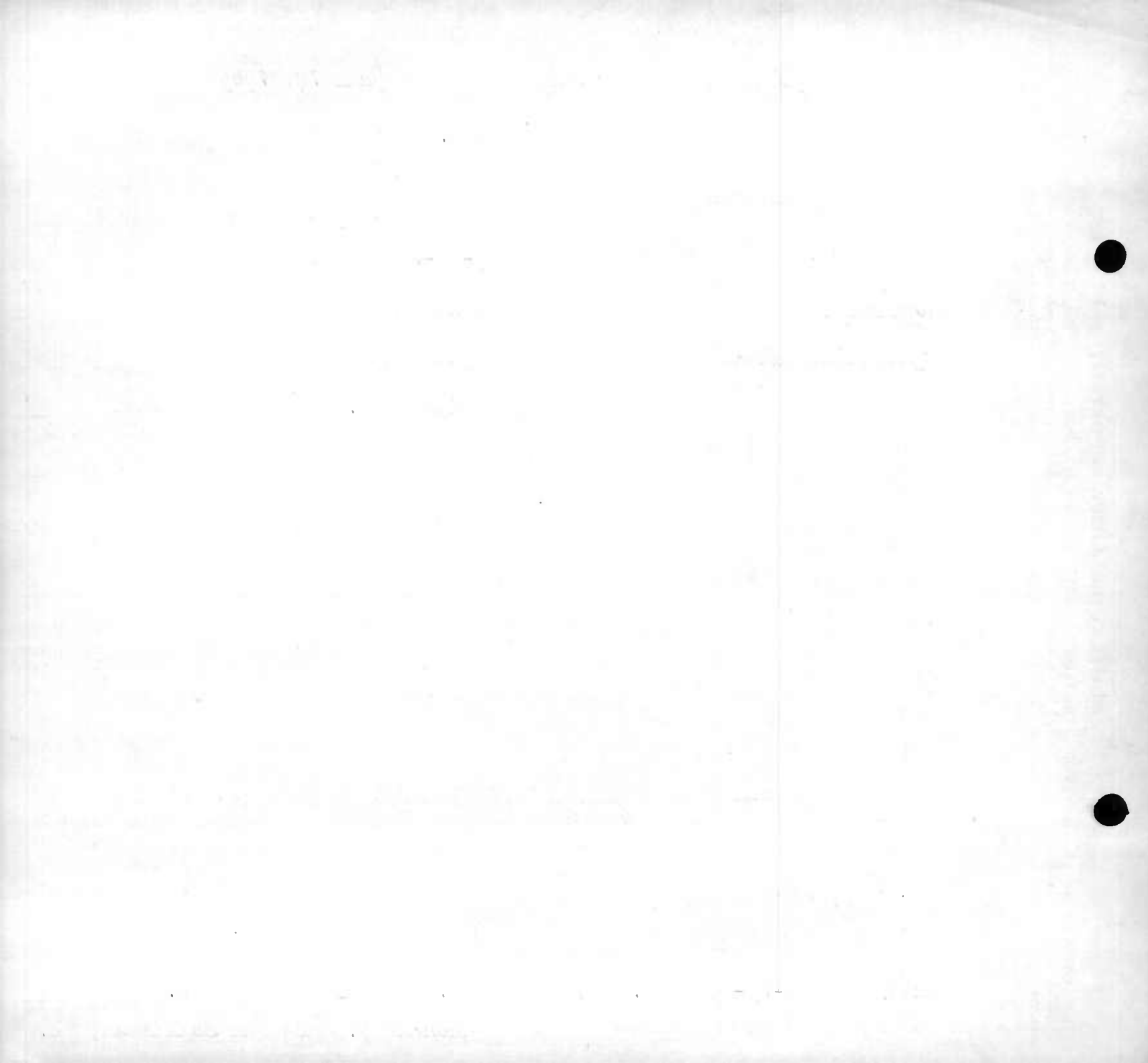
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6256	
BIRTH NO. 65 6256		CERTIFICATE OF DEATH		6/14/65 940 A M.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LUCY CANNON		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 12-05		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 3 JOHNS HOPKINS HOSPITAL		D. STREET ADDRESS (If rural, give location) 1621 LATROBE STREET			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 6-19-1890	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Cumberland Co., Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DEAN PAUL		14. MOTHER'S MAIDEN NAME Lucille DEAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Ruth SIMPKINS ADDRESS 1621 LATROBE STREET	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular Accident		CAUSE OF DEATH (A) DUE TO Probable Myoc. infarction (B) DUE TO Acute hepatic failure (C)		INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 wks 3-4 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6/14 1965 to 6/14 1965 , that (1) (we) last saw the deceased alive on 6/14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Willis C. Maddrey		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/14/65	
23C. PHYSICIAN'S NAME (Type) WILLIS C. MADDREY		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-18-65		24C. NAME of CEMETERY or CREMATORY MT. CALVARY	
24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR Marshall W. Jones, JR.		ADDRESS 1735 Hanford Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

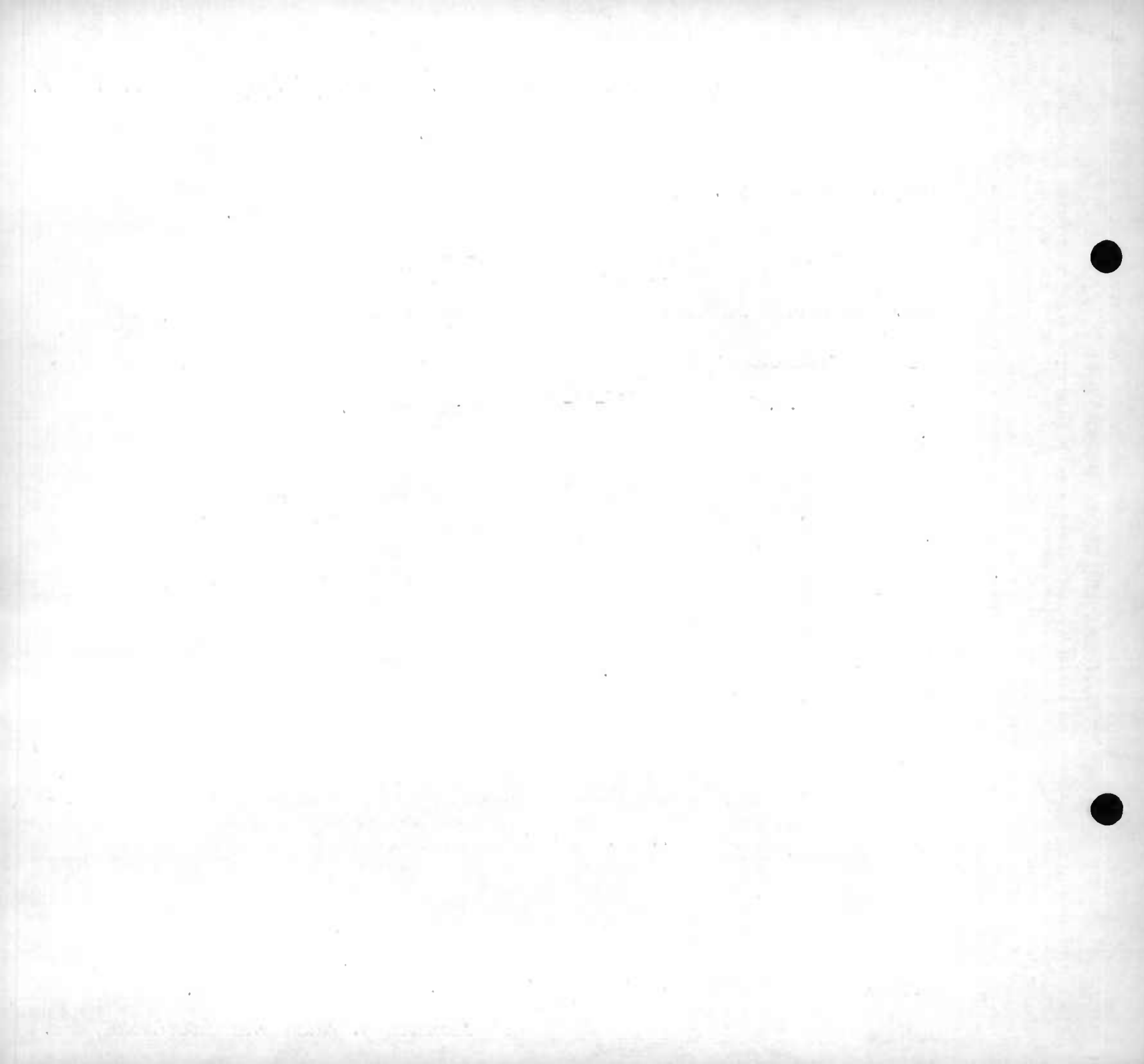
BIRTH NO. 65 6257				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6257	
1. NAME OF DECEASED (Type or Print) <i>Elizabeth Moody</i>				2. DATE AND HOUR OF DEATH <i>June 14, 1965</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>3600 Harford Road</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>7-02</i>			
5. SEX <i>female</i>				6. RACE <i>white</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widowed</i>	
8. DATE OF BIRTH <i>4-22-1882</i>				9. AGE (In years last birthday) <i>83</i>		10. If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Cornelius Bahen</i>				14. MOTHER'S MAIDEN NAME <i>Julie Kirby</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>William J. Moody</i>	
18. ADDRESS <i>same</i>							
1A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				1B. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary occlusion</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>			
1C. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Coronary sclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>5-10 years</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1-19-65</i> 19 to <i>6-14-65</i> 19, that (I) (we) last saw the deceased alive on <i>6-14-65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>C. W. Peake</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>6-15-65</i>			
23C. PHYSICIAN'S NAME (Type) <i>C. W. PEAKE</i>				23D. ADDRESS <i>4508 Harford Rd. Balt. 14 Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>6-17-65</i>		24C. NAME of CEMETERY or CREMATORY <i>St. Michael's Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Frostburg, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 15 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc Baltimore, Md.</i>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

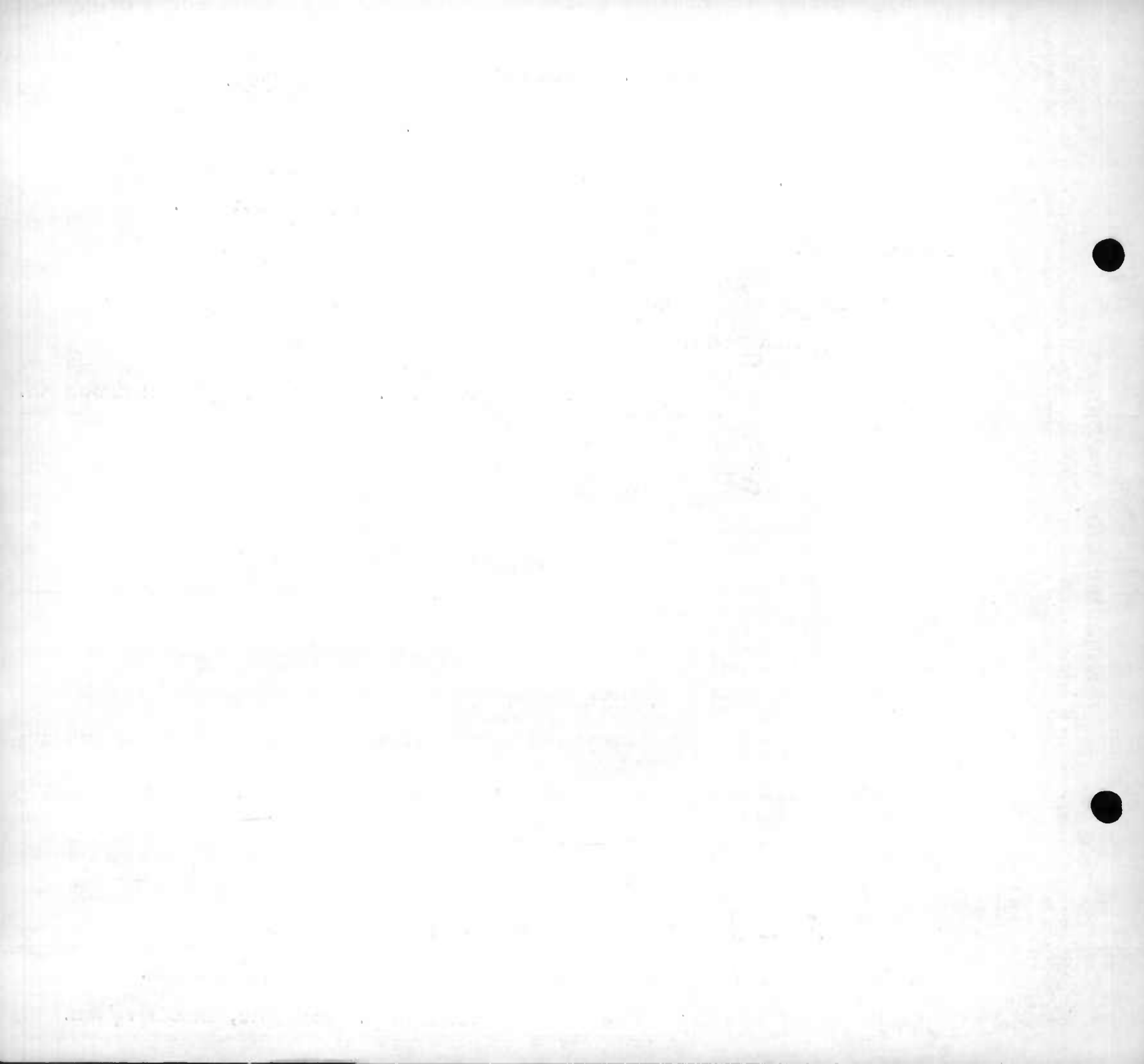
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6258	
BIRTH NO. 65 6258		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		William Joseph Malstrom, Sr.		June 9, 1965 11:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE			
		Md.			
2809 Pinewood Ave.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		2809 Pinewood Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
male	white	married	3-9-1895	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
Ret. Insurance Salesman				USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		17. INFORMANT	
Frank Malstrom		Mary Meehan		Jeannette T. Malstrom	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		ADDRESS	
Yes		W.W. I		same	
		216-03-5523			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		3 months	
		(B) DUE TO		1 month	
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 15 19 65 to June 9 19 65, that (I) (we) last saw the deceased alive on June 8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Philip D. Flynn				6-11-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Philip D. Flynn		11 E. Chase St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
burial		6/14/1965		Baltimore National Cem.	
24D. LOCATION (City, town, or county)		24E. STATE		25A. DATE REC'D BY HEALTH DEPT.	
Baltimore, Md.				JUN 15 1965	
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
Robert E. Taylor		Leonard J. Ruck Inc		Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6259		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6259	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		Anna C. Unkelbach		2. DATE AND HOUR OF DEATH June 13, 1965. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY 8-01	
St. Joseph Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		3107 Belair Rd.	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH May 30, 1889	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Own Home		Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Conrad Bauer		14. MOTHER'S MAIDEN NAME Barbara ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Joseph C. Unkelbach	
				ADDRESS 1519 Burnwood Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I		CAUSE OF DEATH (A) DUE TO Acute Coronary		INTERVAL BETWEEN ONSET AND DEATH Immediate	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) Hypertensive Cardiovascular disease			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from February 1932 to June 13 1965, that (I) (we) last saw the deceased alive on January 3, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Jack J. Singer M.D.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-14-65	
23C. PHYSICIAN'S NAME (Type) JACK J. SINGER		23D. ADDRESS M.D. 117 W-29th St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/16/65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc, Balto 14 Md.	



43-37-34 AM

65 6260

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 6260

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Jennie Marsh

2. DATE AND HOUR OF DEATH

6-12-65

8:48 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland, Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Rural

D. STREET ADDRESS (If rural, give location)

9541 Bauer Avenue #21236

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

3-25-02

9. AGE (In years
lost birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Practical Nurse

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Vennie Pearson

14. MOTHER'S MAIDEN NAME

Mary E. Purcell

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-24-34 56A

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18. 163X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, oshtenio, etc. It means the disease,
injury or complication which caused death.)(A) Cerebral Metastases
DUE TO

1 Month

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) Carcinoma of the Lung
DUE TO

4-6 Months

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-18-19 65 to 6-12-19 65,
that (I) (we) lost saw the deceased alive on 6-12-19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys.Med.
DirectorStaff
Phys. ☒

23B. DATE SIGNED

6-12-65

23C. PHYSICIAN'S
NAME (Type)

Dr. Donald Baltzen

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/15/65

24C. NAME of CEMETERY or CREMATORY

Providence Baptist

24D. LOCATION

(City, town, or county)

Miskimon Virginia

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

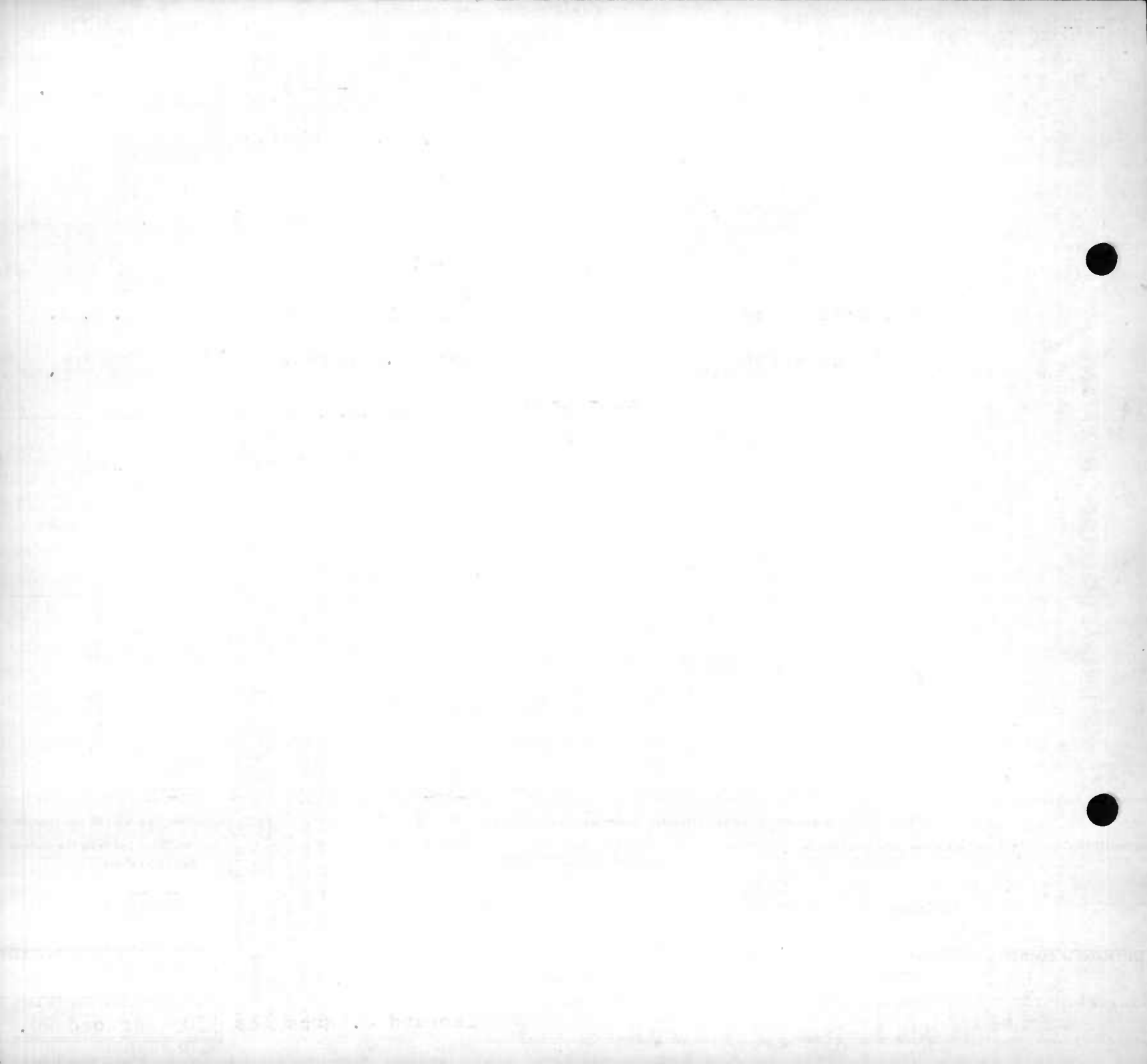
JUN 15 1965

D. B. E. J. J. J.

Leonard J. Ruck Inc 5305 Harford Rd.

FUNERAL DIRECTOR: IMPORTANT

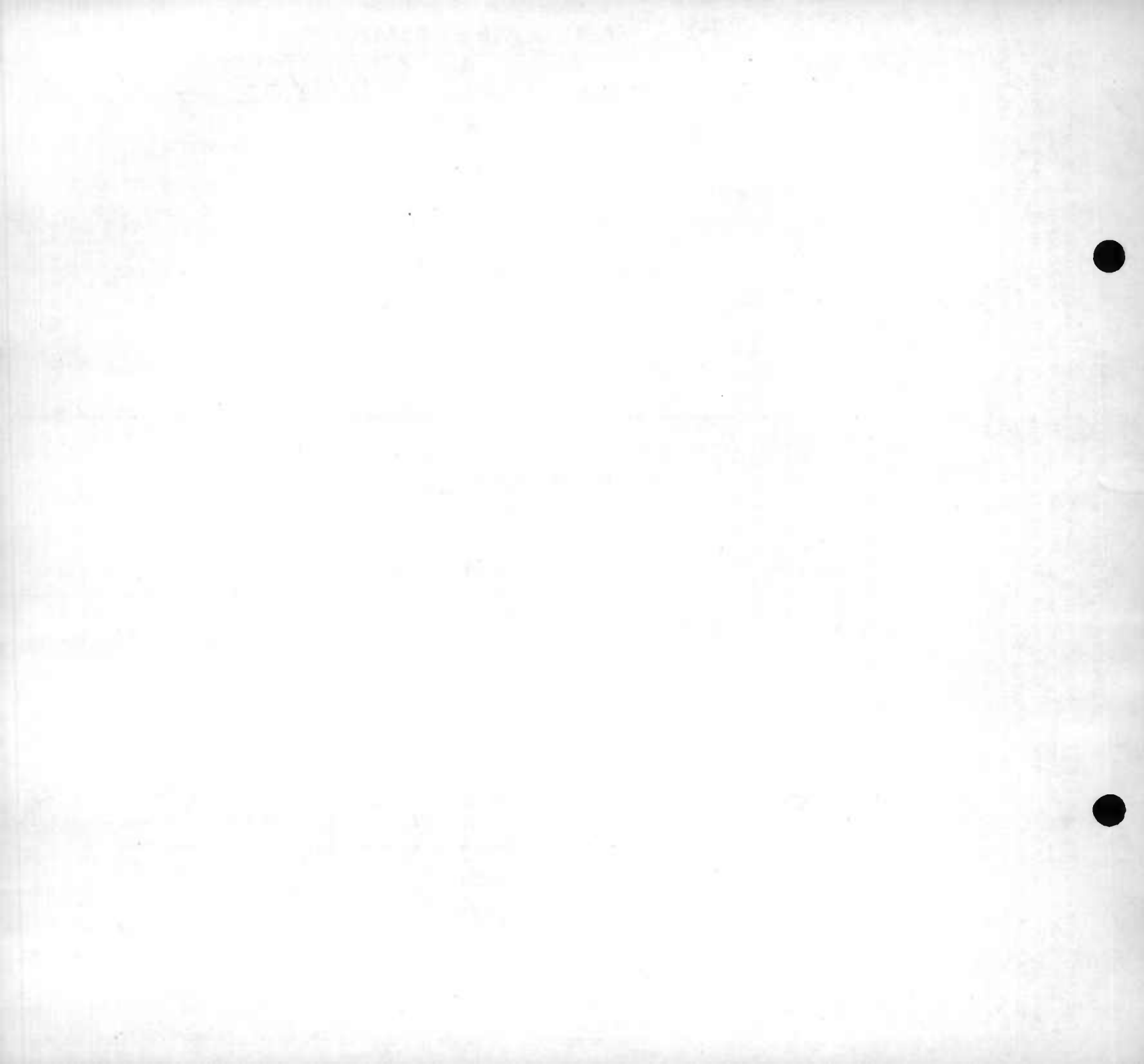
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

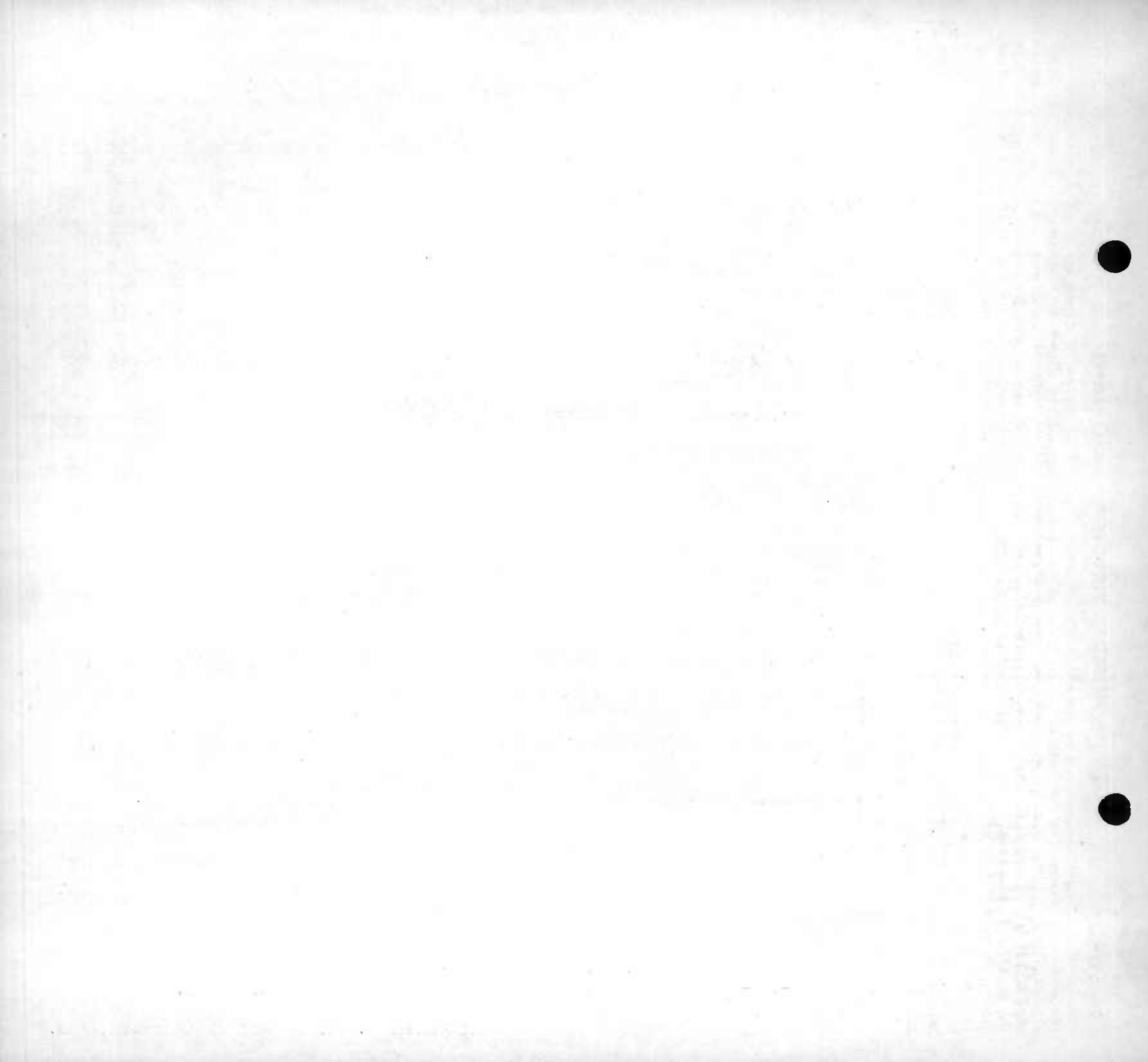
BIRTH NO. 65 6261		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6261	
M.E. CASE NO.		1. NAME OF DECEASED DORATHEA MILLER		2. DATE AND HOUR OF DEATH 6/13/65 11:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md		B. COUNTY 2202	
UNION MEMORIAL HOSP		C. CITY OR TOWN BALTIMORE		D. STREET ADDRESS (If rural, give location)	
		2914 MONTE BELLA TERRACE			
5. SEX R	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 1/16/81	9. AGE (In years last birthday) 84	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John P. MILLER		14. MOTHER'S MAIDEN NAME MARGARET SCHNEIS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-03-6308		17. INFORMANT ADDRESS CASPERINA BECKER MONTEBELLO TERRACE	
18. 572.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) PERITONITIS SECONDARY TO RUPTURED DIVERTICULITIS		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/13 1965 to 6/15 1965, that (I) (we) last saw the deceased alive on 6/13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. SAMAN M.D.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) S. SAMAN	
23D. ADDRESS		23E. ADDRESS		23F. ADDRESS	
UNION MEMORIAL HOSP		UNION MEMORIAL HOSP		UNION MEMORIAL HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/16/65		24C. NAME of CEMETERY or CREMATORY MT. OLIVET CEMETERY	
24D. LOCATION (City, town, or county) BALTO. Md.		24E. LOCATION (City, town, or county)		24F. LOCATION (City, town, or county)	
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR LEONARD J. RUCK, Inc 5305 HARFORD RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 6262					Registered No. 65 6262				
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO.</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <i>Lena Johanna Stevenson</i></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <i>6-13-65</i> <i>12:45</i> <i>AM</i></p> </div> </div>									
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>The Hospital For the Women of Maryland</i></p>					<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <i>Md.</i> B. COUNTY <i>27-38</i></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i></p> <p>D. STREET ADDRESS (If rural, give location) <i>5720 Leith Walk</i></p>				
<p>5. SEX <i>Female</i></p>		<p>6. RACE <i>White</i></p>		<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i></p>		<p>8. DATE OF BIRTH <i>8-28-1883</i></p>		<p>9. AGE (In years last birthday) <i>81</i></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i></p>				<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <i>New York</i></p>		<p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>	
<p>13. FATHER'S NAME <i>Henry Pfort</i></p>					<p>14. MOTHER'S MAIDEN NAME Wasserman <i>Johanna Weisenbach</i></p>				
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unknown</i> <i>217488323</i></p>					<p>16. SOCIAL SECURITY NO. unknown</p>		<p>17. INFORMANT ADDRESS <i>Patients' Chart</i></p>		
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>ASHD + CHF.</i></p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>					<p>CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO</p>		<p>INTERVAL BETWEEN ONSET AND DEATH <i>19 days</i></p>		
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>									
<p>19A. DATE OF OPERATION <i>0</i></p>			<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>			<p>20A. AUTOPSY? (Yes or No) <i>no</i></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>			<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>			<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>			<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>			<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) this hospital attended the deceased from <i>5-26</i> 19 <i>65</i> to <i>6-13</i> 19 <i>65</i>, that (I) last saw the deceased alive on <i>12:45</i> <i>6-13</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did <i>did</i> view the body after death.</p>									
<p>23A. SIGNATURE <i>Joo-Kei Chow</i> M.D.</p>								<p>23B. DATE SIGNED <i>6-13-65</i></p>	
<p>23C. PHYSICIAN'S NAME (Type)</p>					<p>23D. ADDRESS M.D.</p>				
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i></p>		<p>24B. DATE <i>6-16-65</i></p>		<p>24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i></p>		<p>24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i></p>			
<p>25A. DATE REC'D BY HEALTH DEPT. <i>JUN 15 1965</i></p>			<p>25B. NAME OF REGISTRAR <i>Robert E. Jackson</i></p>			<p>25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck Inc Baltimore, Md.</i></p>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6263		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 6263	
1. NAME OF DECEASED (Type or Print) GEORGETTA CANOVA			2. DATE AND HOUR OF DEATH JUNE 12, 1965 12:40 PM.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO C. CITY OR TOWN (If outside city limits, write RURAL and give township) COCKEYSVILLE 53-00 D. STREET ADDRESS (If rural, give location) PADONIA ROAD		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 5-7-1893	9. AGE (In years last birthday) (72) 72	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME PASQUALE BRINDISI			14. MOTHER'S MAIDEN NAME Antoinette Novellas		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218281114	17. INFORMANT HOSPITAL RECORDS		
18. I 171X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) CARCINOMA OF CERVIX DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 9 YEARS
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that it (this hospital) attended the deceased from FEB. 11 1965 to JUNE 12 1965 , that it (we) last saw the deceased alive on JUNE 12 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (it We) (did) (did not) view the body after death.					
23A. SIGNATURE Irving L. Cooperstein M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED JUNE 12, 1965	
23C. PHYSICIAN'S NAME (Type) Irving L. Cooperstein M.D.				23D. ADDRESS MONTEBELLO STATE HOSPITAL, BALTO.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial	24B. DATE 6-15-65	24C. NAME of CEMETERY or CREMATORY Moreland Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 6264	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>Alberta Lucinda Schwartz</u>				2. DATE AND HOUR OF DEATH <u>June 12, 1965 12 Midnight</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>27-02</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>4509 Weitzel Ave.</u>			
5. SEX <u>Female</u>	6. RACE <u>Cauc</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>		8. DATE OF BIRTH <u>1900-8-26</u>		AGE (In years, last birthday) <u>64</u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Joseph Edward Greenholtz</u>				14. MOTHER'S MAIDEN NAME <u>Cora Bell Haines Hines</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213285231</u>		17. INFORMANT <u>Pt's chart</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Inter cerebral Hemorrhage</u> DUE TO (B) <u>Arterio sclerotic Cerebro Vascular Disease</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>22 Hrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <u>June 12, 1965</u> to <u>June 12, 1965</u> . that (I) (we) last saw the deceased alive on <u>June 12, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Charles T. Fletcher</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>June 12, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHARLES T. FLETCHER</u> M.D.				23D. ADDRESS <u>Union Memorial Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>6-16-65</u>		24C. NAME of CEMETERY or CREMATORY <u>Immanuel Lutheran Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md. Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 15 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck Inc Baltimore, Md.</u>			

FIGURE 1

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Wilmer Clements, Sr.

2. DATE AND HOUR PRONOUNCED DEAD

June 13, 1965

1:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3672 Ash Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

June 14, 1893

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Machinist

10B. KIND OF BUSINESS OR INDUSTRY

Poole Foundry

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Walter Clements.

14. MOTHER'S MAIDEN NAME

Emily Jones.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

no

17. INFORMANT

ADDRESS

Helen L. Clements. 3672 Ash St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 13, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/16/65

23C. NAME OF CEMETERY or CREMATORY

Lorraine Park

23D. LOCATION

(City, town, or county)

Windsor Mill Rd, Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 15 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Austin E. Donovan, 3818 Roland Ave

ADDRESS

WATLEY & BOWEN

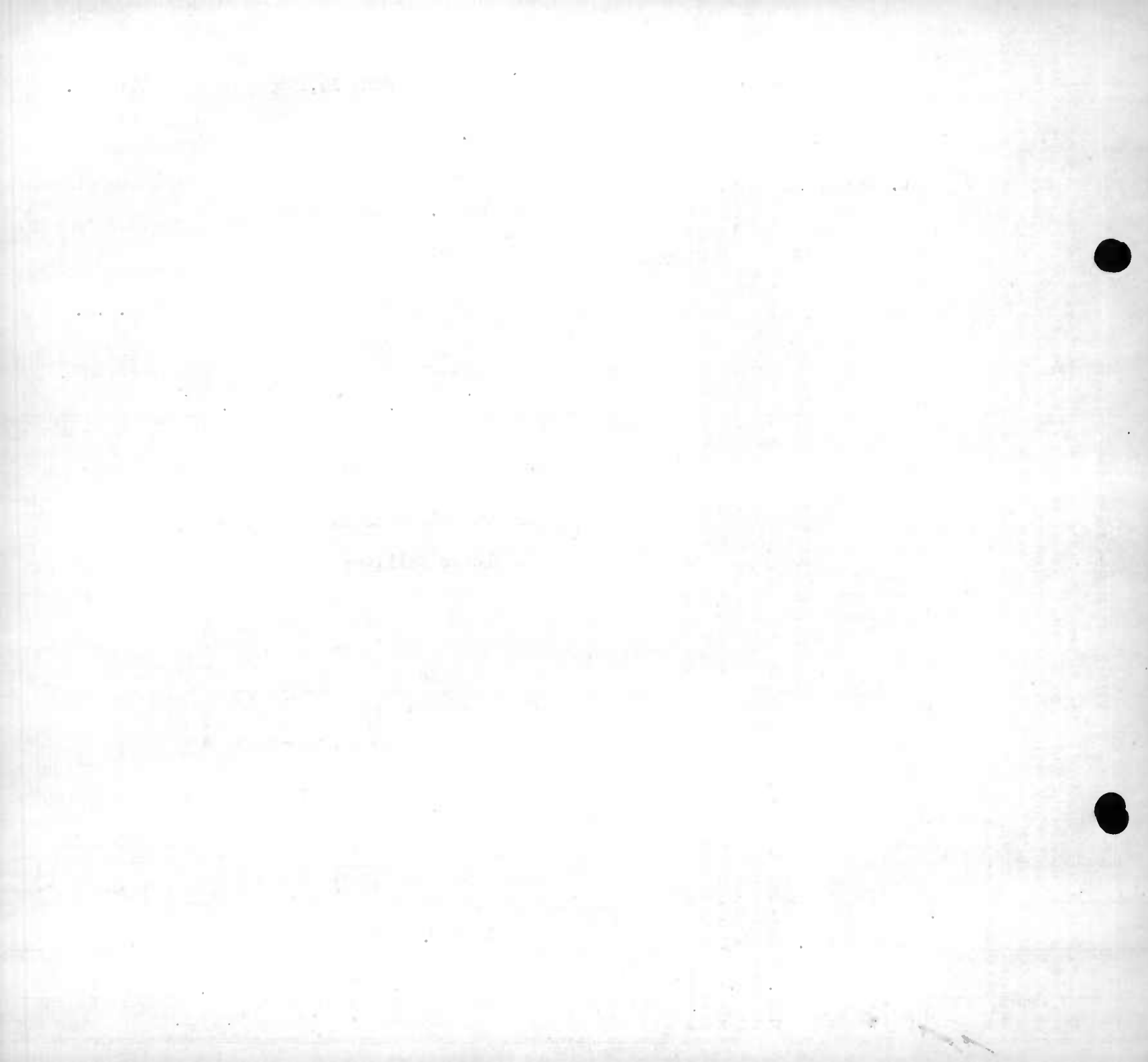
no no
Helen L. Clements. 3072 Ann St.
Bally Jones.
Retired Technical Book Boundary
Maryland U.S.
June 11, 1993 71

Final 5/16/93
Hortense Park
Witness Will be, Mr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6266	
BIRTH NO. 65 6266		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		PEACOCK, MARY (MARY EVA PEACOCK)		June 14, 1965 10:05 P. M. 7-01	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital		A. STATE Md.			
(If not in hospital or institution, give street address or location)		B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 21205			
		D. STREET ADDRESS (If rural, give location) 740 N. Linwood Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months: Days: Hours: Min.
Female	White	Widowed	6/29/87	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Ebenezer Smith		Araminta Gardner		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		none		Mr. Samuel M. Peacock Jr. 734 N. Linwood Ave.	
18. 260X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Acute Pulmonary Edema			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B) Arteriosclerotic Heart Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO			
		(C) Diabetic Mellitus			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
O				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from June 14 19 65 to June 14 19 65 , that (I) (we) last saw the deceased alive on June 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Glocrito G. Sagisi M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				6/14/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Glocrito G. Sagisi		1400 N. Caroline Street			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	June 18, 1965	Oak Lawn Cemetery	Baltimore Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
JUN 16 1965	Robert E. Fisher, M.D.	HENRY SANDER & SONS, INC.		Baltimore Md.	



BALTIMORE CITY HEALTH DEPARTMENT

65 6267 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 6267

BIRTH NO. 65 6267

M-560

1. NAME OF DECEASED (Type or Print) **Aubrey Minor (AUBREY ELLIS MINOR)**

2. DATE AND HOUR PRONOUNCED DEAD **June 12, 1965 1:30 P. M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **2638 N. Charles Street**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore 21218 12-06**

D. STREET ADDRESS (If rural, give location) **2638 N. Charles Street**

5. SEX **Male**

6. RACE **White**

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) **widowed**

8. DATE OF BIRTH **May. 17. 1884**

9. AGE (In years lost birthday) **81**

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Electrician**

10B. KIND OF BUSINESS OR INDUSTRY **Retired 10 yrs.**

11. BIRTHPLACE (State or foreign country) **Baltimore Md.**

12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Charles Hundley Minor**

14. MOTHER'S MAIDEN NAME **Sarah Sisson**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **no**

16. SOCIAL SECURITY NO. **216-18-3401**

17. INFORMANT **Mr. Charles F. Obrecht**

ADDRESS **Benfield Rd. Millersville, Md.**

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) **Arteriosclerotic Cardiovascular Disease**

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) **no**

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **John E. Adams** M.D. CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) **John E. Adams, M.D.** ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **June 13, 1965**

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial**

23B. DATE **June. 15. 1965**

23C. NAME of CEMETERY or CREMATORY **Loudon Park Cemetery**

23D. LOCATION (City, town, or county) (State) **Baltimore Md.**

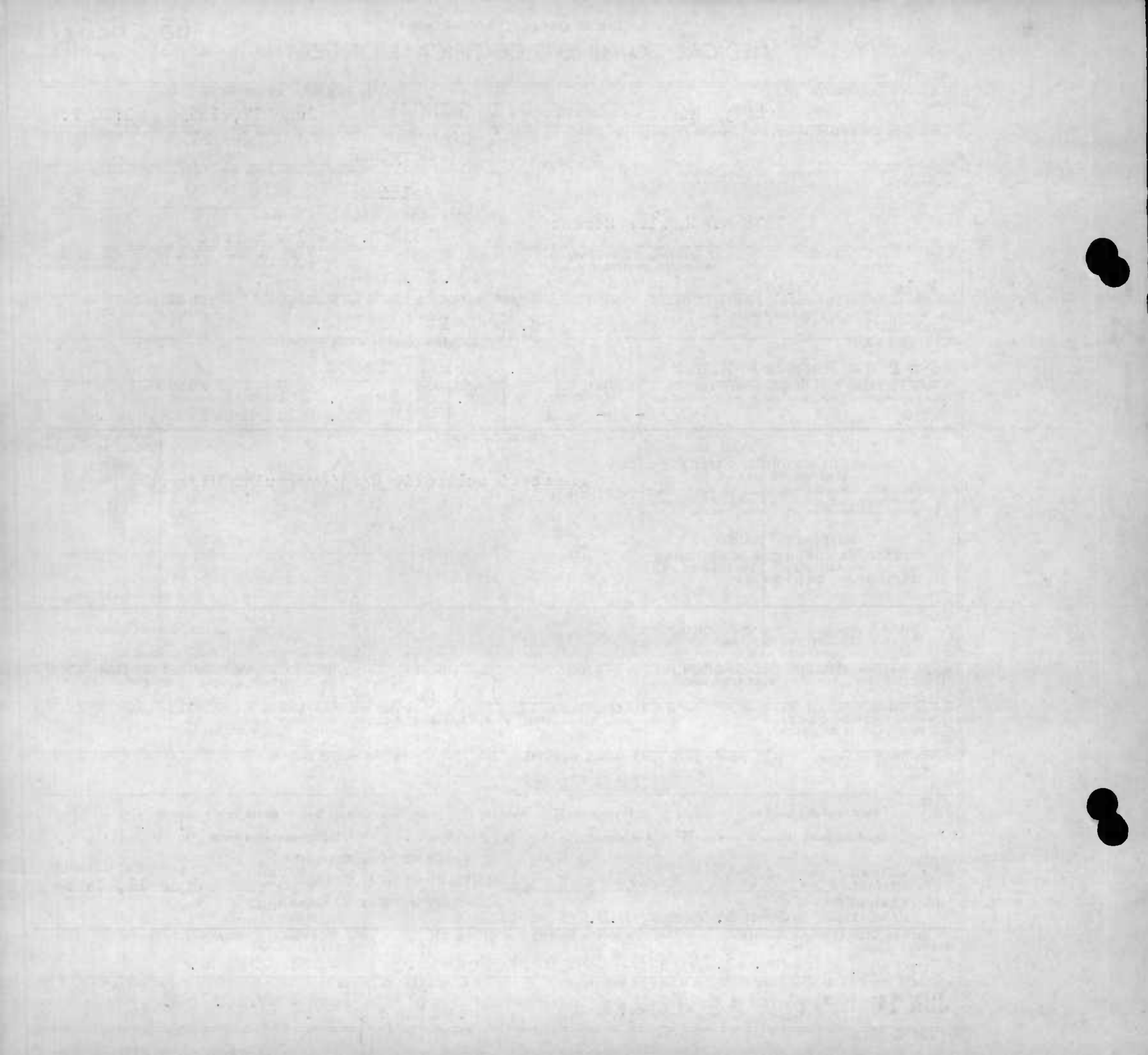
24A. DATE REC'D BY HEALTH DEPT. **JUN 16 1965**

24B. NAME OF REGISTRAR **Robert E. Farley, M.D.**

24C. FUNERAL DIRECTOR **HENRY SANDER & SONS, INC.**

ADDRESS **Baltimore Md.**

VS 151-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

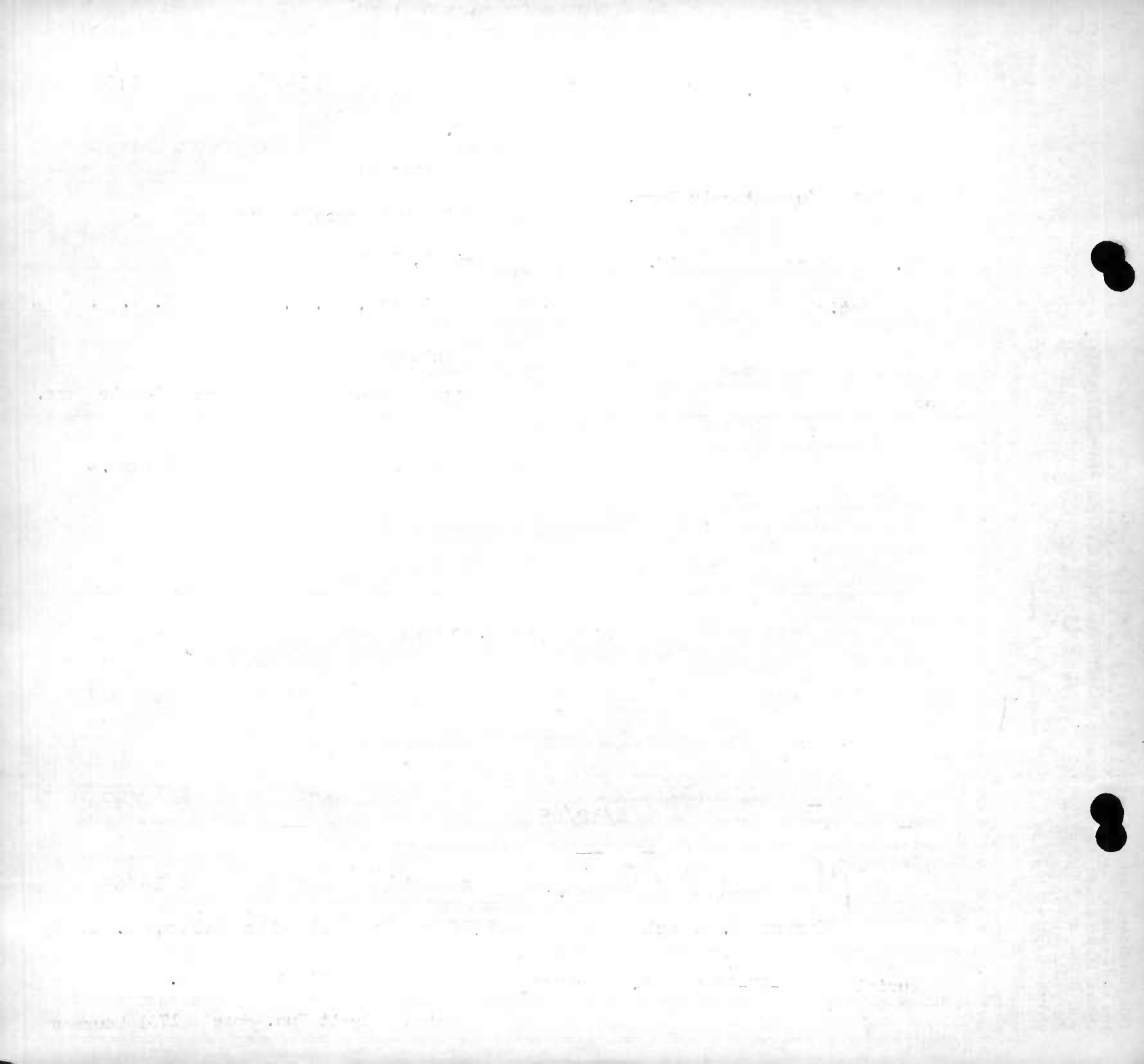
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
8. DATE OF BIRTH		9. AGE (In years lost birthday)		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		7 days?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		5 days?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO		?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-3-65 to 6-12-65, that (I) (we) last saw the deceased alive on 6-12-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE H. Gerard Oster M.D.		23B. DATE SIGNED 6/12/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		25D. ADDRESS			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

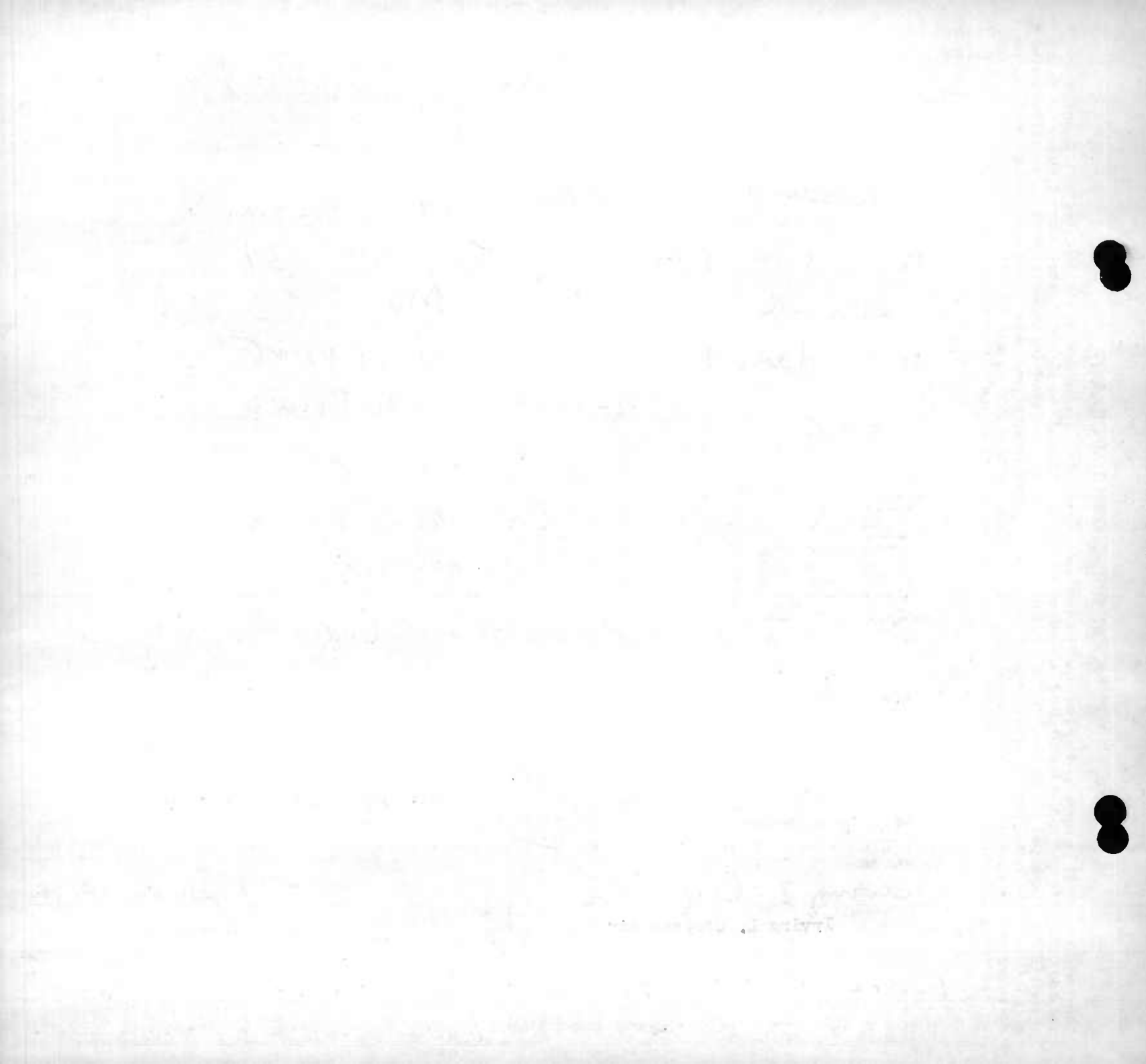
BIRTH NO. 65 6269				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6269	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MARY T. COLEMAN				2. DATE AND HOUR OF DEATH 6/14/65 1:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3302 Auchentoroly Terr.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 13-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3302 Auchentoroly Terrace			
5. SEX Fe.	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Wid.	8. DATE OF BIRTH April 1, 1897	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.		
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME				
14. MOTHER'S MAIDEN NAME Unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				
16. SOCIAL SECURITY NO.			17. INFORMANT Valia Newman 3302 Auchentoroly Terr.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma stomach				INTERVAL BETWEEN ONSET AND DEATH 6 mos. +			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes mellitus				5 yrs +			
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 48 to 6/14/65 19 65 and that (I) (we) lost saw the deceased alive on 6/12/65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Thomas E. Roach</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/14/65	
23C. PHYSICIAN'S NAME (Type) Thomas E. Roach				23D. ADDRESS M.D. 5550 Balto Natl Pike Balto, Md. 21228			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-17-65		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR Morton & Dyett Fun. Home		ADDRESS 1701 Laurens	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Certificate of Death		Registered No. 65 6270	
BIRTH NO. 65 6270		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HENRY THOMAS HOOKER		2. DATE AND HOUR OF DEATH JUNE 13 1965 5:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MD.		B. COUNTY 15-04	
MONTEBELLO STATE HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.			
				D. STREET ADDRESS (If rural, give location) 2114 N. PULASKI ST.			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH DEC. 8 1910	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME THOMAS HOOKER				14. MOTHER'S MAIDEN NAME VALENTINE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-03-3691		17. INFORMANT HOSPITAL RECORD		ADDRESS	
18. 322.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 6 MOS	
ANTECEDENT CAUSES				(A) PARAPLEGIA DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) CNS DEGENERATION DUE TO			
				(C) ALCOHOLISM			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from APRIL 14 1965 to JUNE 13 1965, that (H) (we) last saw the deceased alive on JUNE 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Irving L. Cooperstein M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED JUNE 13, 1965	
23C. PHYSICIAN'S NAME (Type) Irving L. Cooperstein				23D. ADDRESS MONTEBELLO STATE HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-17-65		24C. NAME of CEMETERY or CREMATORY MT. AUBURN		24D. LOCATION (City, town, or county) BALTO. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 15 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR ADDRESS MORTON & Dye F.H. 1701 LAURENS ST.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6271	
BIRTH NO. 65 6271		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) John P. Oliver		2. DATE AND HOUR OF DEATH June 12, 1965 7:20 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland B. COUNTY 19-03	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 3045 Stricker St.	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept. 20, 1910
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Gasoline Station	9. AGE (In years last birthday) 54
13. FATHER'S NAME Peter Oliver		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 235-16-6820	
		17. INFORMANT Minnie E. Oliver 3045 Stricker St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 289.2		CAUSE OF DEATH Pulmonary edema	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Hemochromatosis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) DUE TO	
		(C)	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1960 to June 12, 1965 , that (I) (we) last saw the deceased alive on June 12, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Stanley Ankudav		23B. DATE SIGNED 6-14-65	
23C. PHYSICIAN'S NAME (Type) STANLEY ANKUDAS M.D.		23D. ADDRESS 1802 W. Boet & Boet St	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/16/65	24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1965		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Walters Funeral Home		ADDRESS 3045 Stricker St.	

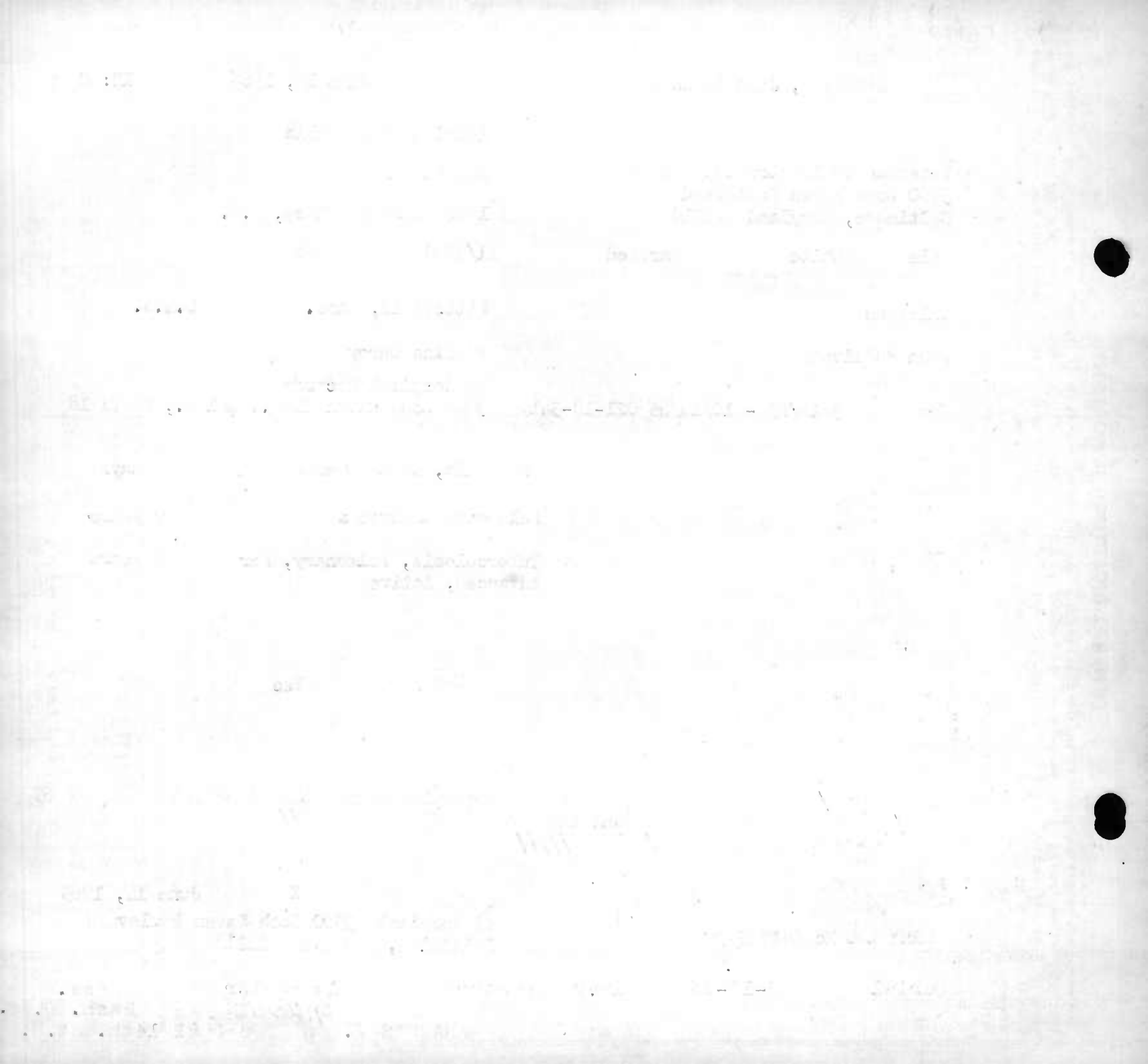
Palmerston Island
H. M. S. Challenger

June 15 1875

ST. JOHN'S BATHS
✓ 6150
also 6150

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6272		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6272	
M.E. CASE NO.			1. NAME OF DECEASED		
(Type or Print)			SULLIVAN, John Leonard		
2. DATE AND HOUR OF DEATH			June 14, 1965 12:40 p.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Veterans Administration Hospital			District of Columbia		
3900 Loch Raven Boulevard			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
Baltimore, Maryland 21218			Washington		
5. SEX			D. STREET ADDRESS (If rural, give location)		
Male			1142 Somerset Place, N.W.		
6. RACE			E. DATE OF BIRTH		
White			11/8/08		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)			9. AGE (In years lost birthday)		
Married			56		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Salesman			Pittsfield, Mass.		
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
John Sullivan			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
Yes			23/4/43 - 10/14/45 021-18-3419		
17. INFORMANT			ADDRESS		
VA Hospital Records			3900 Loch Raven Blvd., Balto., Md 21218		
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) Pneumonia, Left Lower Lobe		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			DUE TO		
ANTECEDENT CAUSES			(B) Pulmonary Emphysema		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO		
II			(C) Tuberculosis, Pulmonary, Far Advanced, Active		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from September 26th 19 61 to June 11th 19 65, that (1) (we) last saw the deceased alive on June 11th 19 65 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Mary Lou McIlhane				June 14, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
MARY LOU McILHANEY				VA Hospital 3900 Loch Raven Boulevard	
				Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-17-65		Calvary Cemetery	
				Gloucester	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 16 1965		Robert E. Feltman		Francis J. Collins	
				Wash. D. C.	
				FRANCIS J. COLLINS 3821 14th. St. N.W.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>65-07585</u> <u>6273</u>		CERTIFICATE OF DEATH		Registered No. <u>65</u> <u>6273</u> <u>4</u>	
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL MILLER</u>			2. DATE AND HOUR OF DEATH <u>3/14/65</u> <u>6 PM</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bon Secours Hospital</u> <u>2025 West Fayette Street, Balto. Md.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>MD</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 21223 MARYLAND</u> D. STREET ADDRESS (If rural, give location) <u>1125 S Carey St 21-02</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>—</u>	8. DATE OF BIRTH <u>3/14/65</u>	9. AGE (In years lost birthday) <u>3</u> <u>35</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			13. FATHER'S NAME <u>Malvern Milroy Miller</u>		
14. MOTHER'S MAIDEN NAME <u>Marjorie Ann Marsh</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		
16. SOCIAL SECURITY NO. <u>—</u>			17. INFORMANT <u>Hospital Records</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>776X I</u> <u>Immaturity</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs 35 min.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>—</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>—</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>—</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>			
21D. TIME OF INJURY (APPROX.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>3/14/65</u> 19 to <u>3/14/65</u> 19, that (I) (we) last saw the deceased alive on <u>3/14/65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. Gomez</u>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Chief Resident <input checked="" type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5/11/65</u>
23C. PHYSICIAN'S NAME (Type) <u>A. Gomez</u>			23D. ADDRESS <u>Bon Secours Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/15/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>St Peter's</u>	
24D. LOCATION (City, town, or county) (State) <u>Beth Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 16 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Thomas J. Kennedy</u>		ADDRESS <u>Balto Md 6/15/65</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6274				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6274	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ANNA B. ERDMAN				2. DATE AND HOUR OF DEATH JUNE 13, 1965			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1033 FOREST ST.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 10-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO, MD. D. STREET ADDRESS (If rural, give location) 1033 FOREST ST.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH NOV. 11, 1886	9. AGE (In years lost birthday) 78	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PACKER		10B. KIND OF BUSINESS OR INDUSTRY LAB PACKING CO		11. BIRTHPLACE (State or foreign country) BALTO, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES WICKES			14. MOTHER'S MAIDEN NAME AGNES ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-01-4957		17. INFORMANT FAMILY		ADDRESS SAME	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ARTERIOSCL.C.V. DI'S. DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCL. GENERAL DUE TO INTERVAL BETWEEN ONSET AND DEATH 2 YRS. 5 YRS.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 1955 to 6-13-65 that (I) (we) last saw the deceased alive on 6-12-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Benjamin B. Moses, M.D.				23B. DATE SIGNED 6-15-65			
23C. PHYSICIAN'S NAME (Type) BENJAMIN B. MOSES				23D. ADDRESS 448 N. LUZERNE AVE. BALTO, MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-16-65		24C. NAME OF CEMETERY OR CREMATORY ST. PETERS CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR J. Walter Conklin			
				ADDRESS 5444 BELAIR RD			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6275	
BIRTH NO. 65 6275		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ELMORE BAILEY		2. DATE AND HOUR OF DEATH June 9, 1965 1330 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		A. STATE Maryland B. COUNTY 4-11			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 315 N. Penn St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) ?	8. DATE OF BIRTH 3/27/90	9. AGE (in years lost birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman?		10B. KIND OF BUSINESS OR INDUSTRY Lumber Yard		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ? Harry O. Bailey		14. MOTHER'S MAIDEN NAME Emily Drane	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown - No -		16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS Medical Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 331X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO Bacterial shock		2 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Protein nephropathy		1 wk.	
		(C) CVA		10 days	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 29 1965 to June 9 1965 , that (I) (we) lost saw the deceased alive on June 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE BARRY N. ROSENBAUM				23B. DATE SIGNED June 9, 1965	
23C. PHYSICIAN'S NAME (Type) BARRY N. ROSENBAUM M.D.				23D. ADDRESS UNIVERSITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) cremation		24B. DATE 6.12.65		24C. NAME OF CEMETERY or CREMATORY Greenmount Crematorium	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. LOCATION (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Pennington & Son	
				ADDRESS Havre de Grace, Md	



FUNERAL DIRECTOR: IMPORTANT

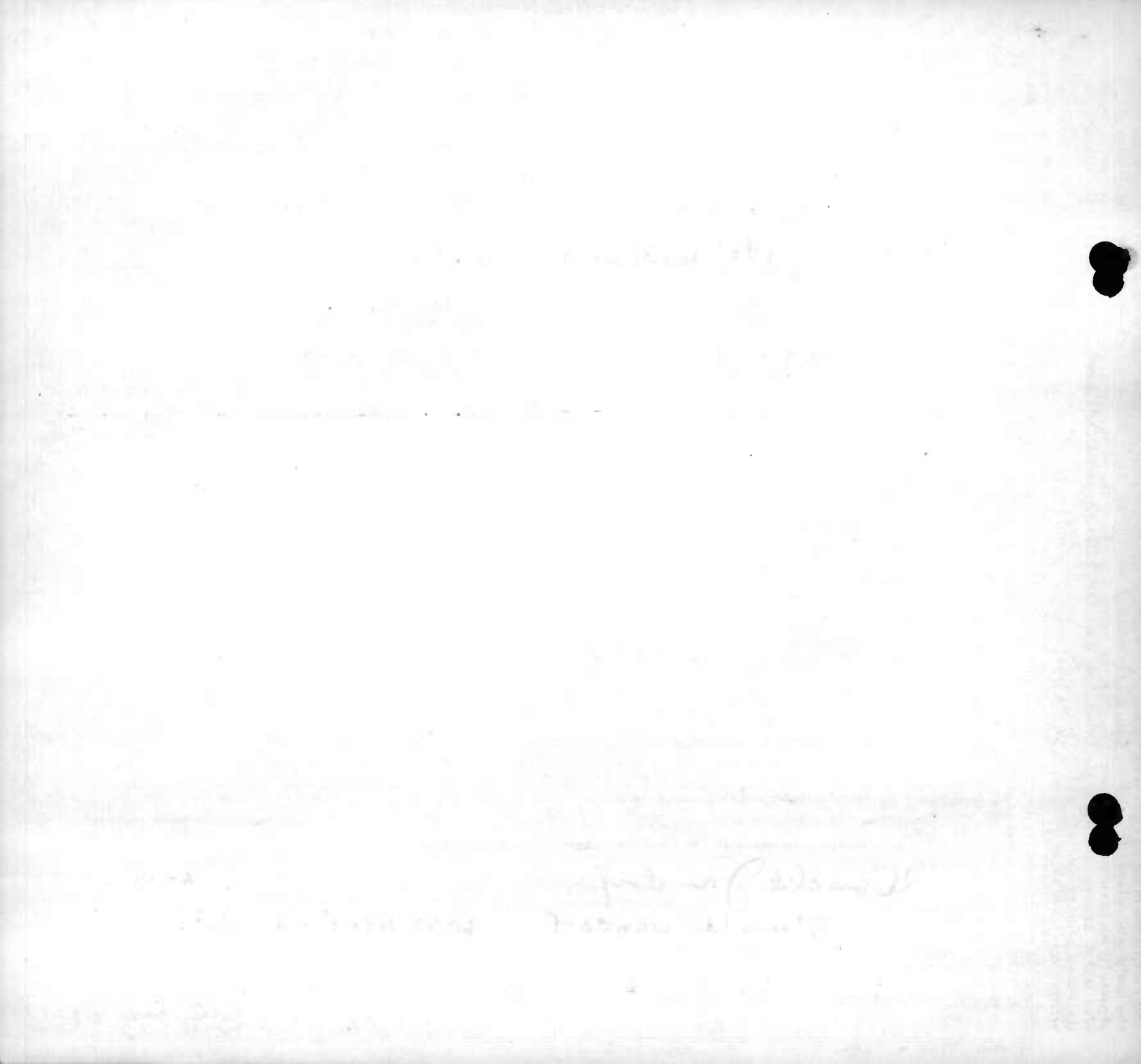
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6276	
BIRTH NO. 65 6276		CERTIFICATE OF DEATH			
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Clara Emelia Garis			June 13, 1965 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3802 Barrington Road Baltimore, Maryland			A. STATE Maryland B. COUNTY 15-10		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 3802 Barrington Road 21215		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH May 22, 1867	9. AGE (In years lost birthday) 98	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick, Md.	
13. FATHER'S NAME Wilhelm Adam			12. CITIZEN OF WHAT COUNTRY?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Ambassador Apts. Baltimore, Md. 18	
18. 443X 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Hypertensive Arteriosclerotic Heart Dis. DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 20 yrs. +	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1 1935 to June 13 1965 , that (I) (we) last saw the deceased alive on May 31 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Robert W. Garis, M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED June 15, 1965	
23C. PHYSICIAN'S NAME (Type) ROBERT W. GARIS M.D.				23D. ADDRESS 12 E. EAGER ST., BALTIMORE-2, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/16/1965		24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery	
				24D. LOCATION (City, town, or county) (State) Frederick, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1965		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR ADDRESS Wm. J. Finkbeiner & Son Baltimore, Md. 21217 North & E. Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

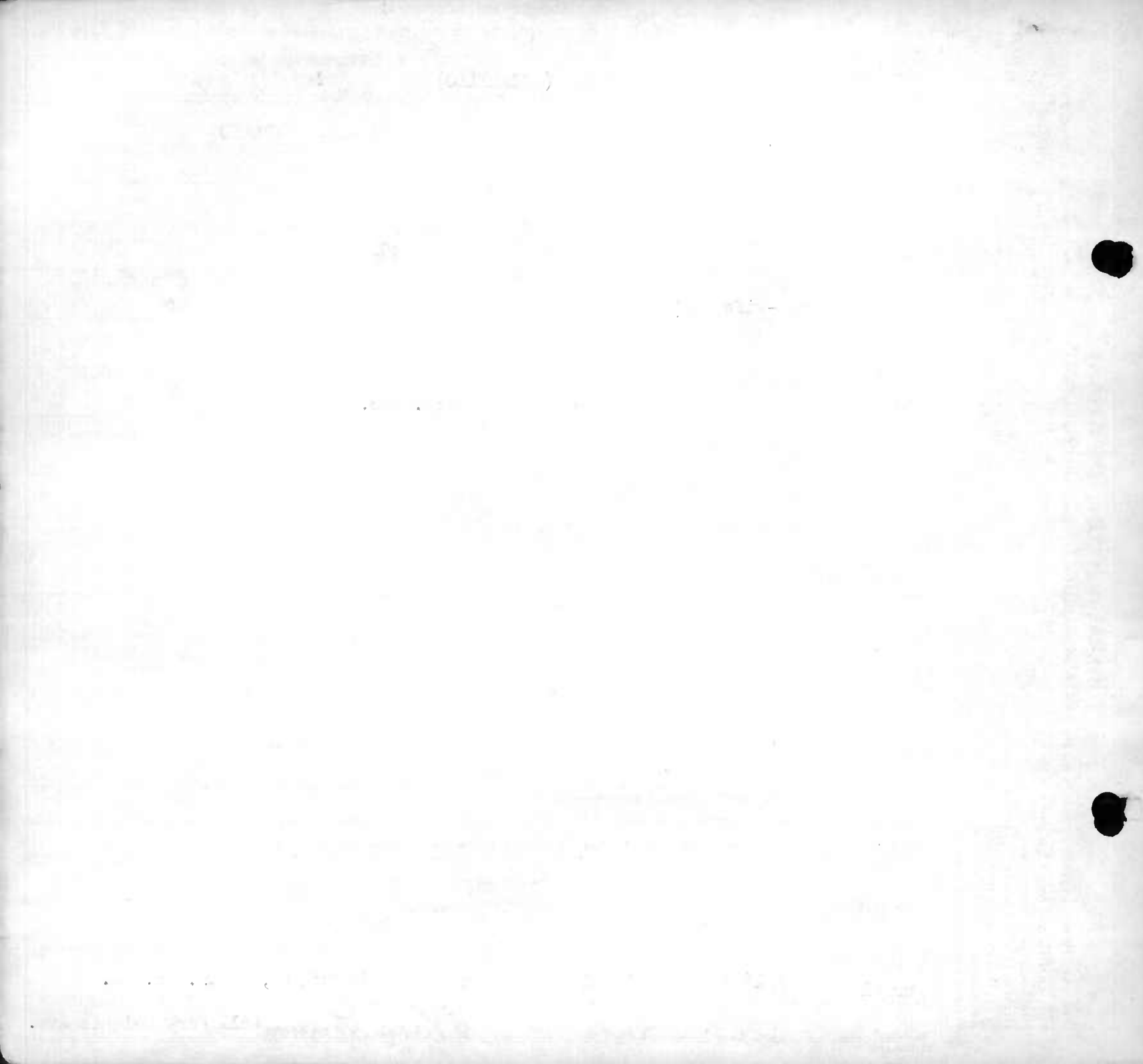
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6277	
BIRTH NO. 65 6277		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Rena Strauss Jandorf		2. DATE AND HOUR OF DEATH 6-14-65 1 6 ⁴⁵ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2525 Eutaw Place Baltimore, Maryland 21217		A. STATE Md. B. COUNTY 13-01		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 2525 Eutaw Place 21217			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Aug. 20, 1885	9. AGE (In years last birthday) 79	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Richmond, Va.	
13. FATHER'S NAME David Strauss		14. MOTHER'S MAIDEN NAME Fannie Bachrach		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 220-44-4022		17. INFORMANT ADDRESS 6405 Western Run Dr. Baltimore, Md. 15	
18. 153-0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Cancer cecum DUE TO		INTERVAL BETWEEN ONSET AND DEATH 7 mos.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from June 15 1960 to 6/14/1965 that (I) (the hospital) last saw the deceased alive on 6/13/1965 and that in (my) (the hospital) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (the hospital) (did not) view the body after death.					
23A. SIGNATURE R Donald Jandorf M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-14-65	
23C. PHYSICIAN'S NAME (Type) R Donald Jandorf M.D.		23D. ADDRESS 6077 Hanford Rd			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/14/1965		24C. NAME of CEMETERY or CREMATORY Baltimore Hebrew Cemetery	
				24D. LOCATION (City, town, or county) Baltimore, Maryland (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1965		25B. NAME OF REGISTRAR Robert E. Fackler		25C. FUNERAL DIRECTOR Wm. J. Fickner & Sons Baltimore, Md. 21217	



FUNERAL DIRECTOR: IMPORTANT

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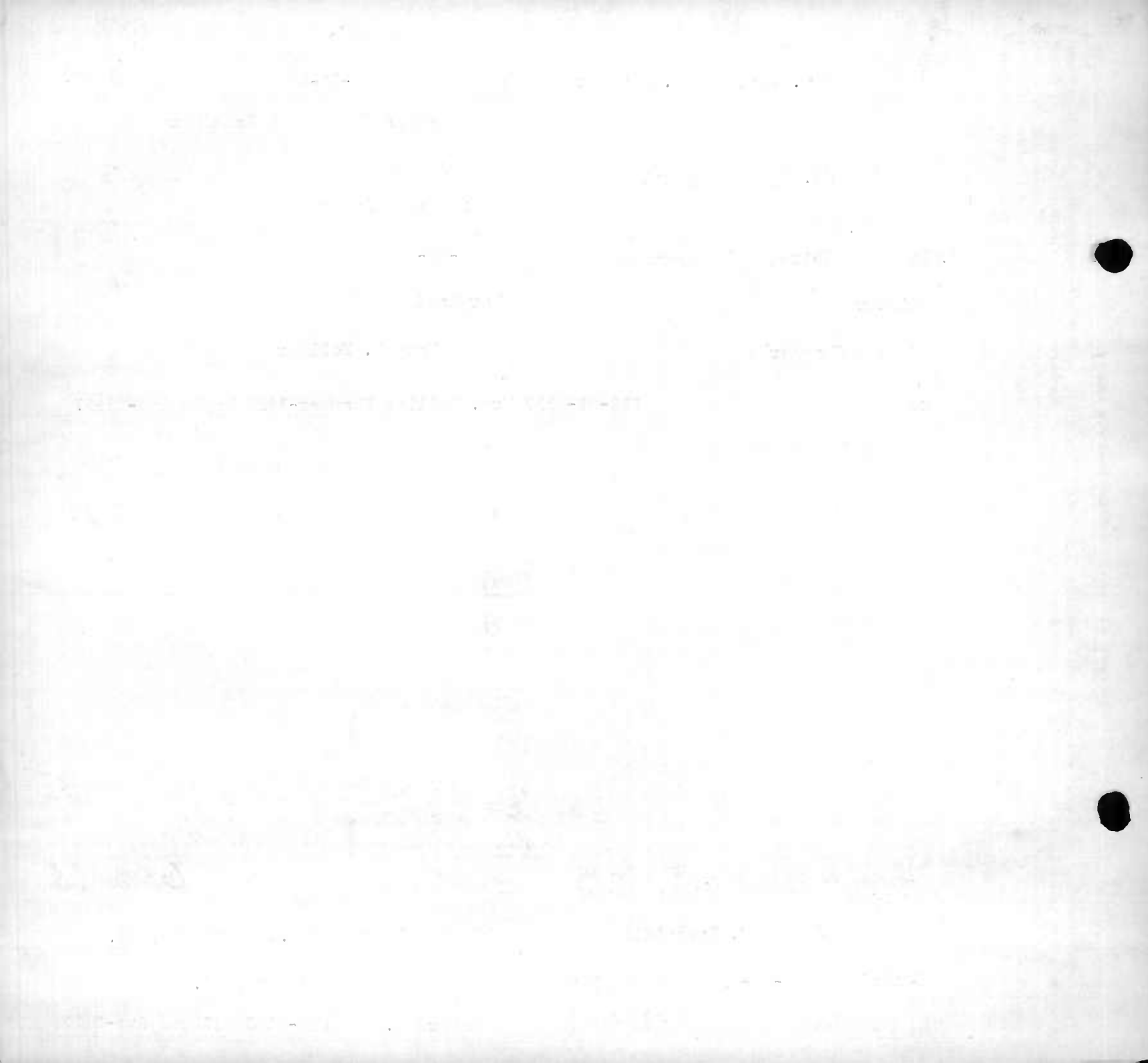
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6278	
BIRTH NO. 65 6278		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MRS. CONCETTA AZARELLO (AZZARELLO)		2. DATE AND HOUR OF DEATH JUNE 13, 1965 11:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL		A. STATE BALTIMORE, MARYLAND B. COUNTY 27-16			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 4705 PARK HEIGHTS AVENUE (15)			
		D. STREET ADDRESS (If rural, give location)			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH JUNE 24, 1886	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY House-wife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME SAM PITARRA		14. MOTHER'S MAIDEN NAME MARIANNA D'ALFONSO	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Hosp. Rec.	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardio-pulmonary failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardiovascular Disease		CAUSE OF DEATH (A) Cardio-pulmonary failure DUE TO (B) Arteriosclerotic Cardiovascular Disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH years years.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 11 19 65 to JUNE 13 19 65 , that (I) (we) last saw the deceased alive on JUNE 13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose V. de Leon, Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) JOSE V. DE LEON, JR.		23D. ADDRESS BON SECOURS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/16/65		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1965		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Robert E. Farkner	
				ADDRESS 4611 Park Heights Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

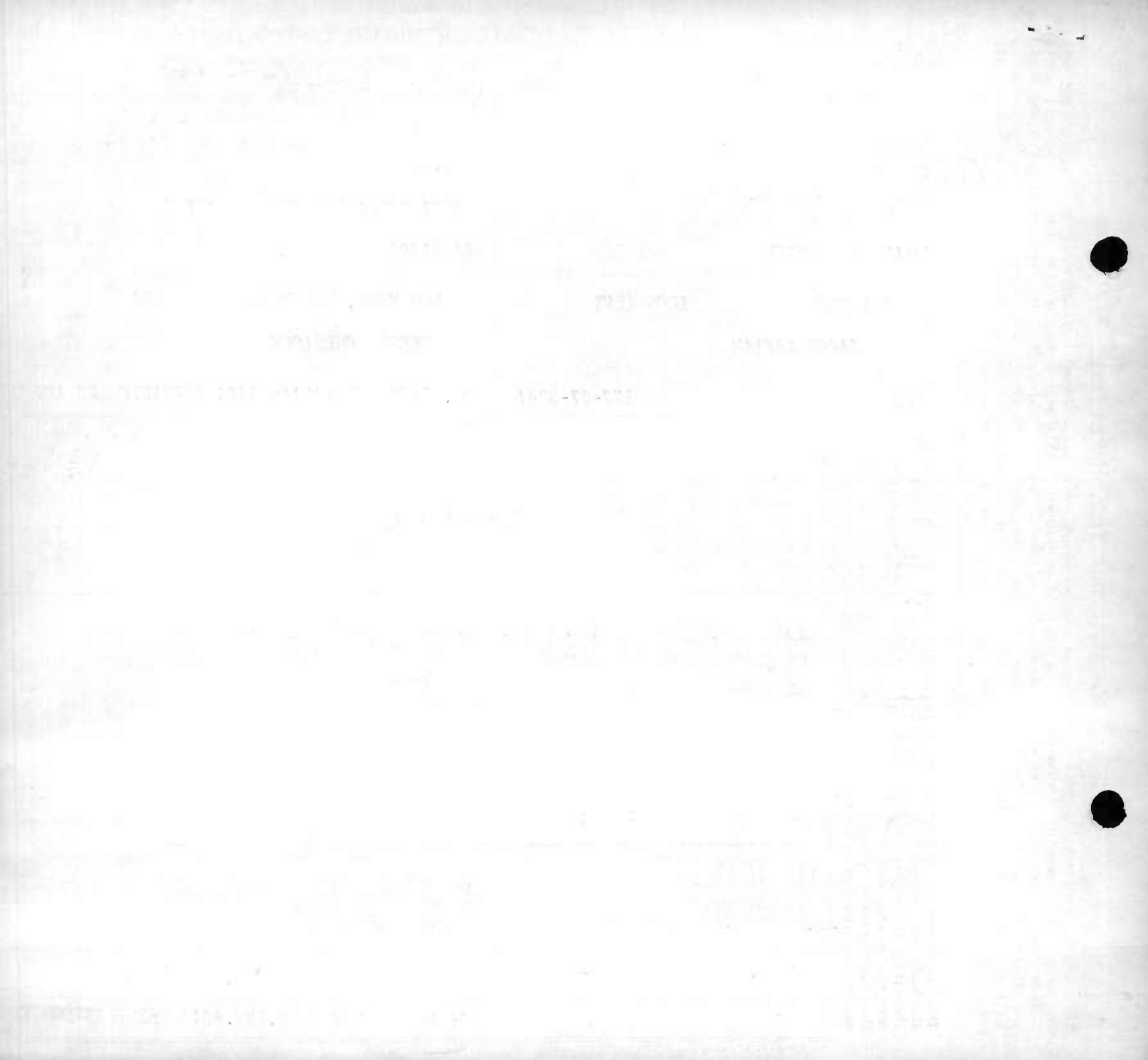
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO.		65 6279		CERTIFICATE OF DEATH			Registered No. 65 6279		
M.E. CASE NO.				1. NAME OF DECEASED			2. DATE AND HOUR OF DEATH		
				Rev. Clarence R. Shawker			6-12-65 2 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY			
St. Agnes Hospital				Maryland		Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
				Arbutus					
				D. STREET ADDRESS (If rural, give location)					
				1258 Maple Avenue					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
Male	White	Married		2-17-88	77				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Minister				Maryland					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
George Shawker				Mary E. Follmer					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
No		214-01-6557		Mrs. Lillian Shawker-1258 Maple Ave-21227					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			Acute Cardiac Failure 1 hr		
ANTECEDENT CAUSES				(B) DUE TO			Cardiovascular Renal Disease 10 yr		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 4-10-50 to 6-12-65, that (I) (we) last saw the deceased alive on 6-12-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE						23B. DATE SIGNED			
Joseph G. Laukaitis M.D.						6/14/65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Joseph G. Laukaitis				679 Washington Blvd., Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		6-16-65		Loudon Park		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			ADDRESS		
JUN 16 1965		Robert E. Farber M.D.		Howard H. Hubbard-4107 Wilkens Ave-21229					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6280	
BIRTH NO. 65 6280		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KAPLAN, GEORGE Abraham		2. DATE AND HOUR OF DEATH June 14, 1965 12 noon M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LEVIN DALE HEBREW HOME AND INFIRMARY.		A. STATE MARYLAND		B. COUNTY 27-20	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 3801 FORDLEIGH ROAD APT D			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4/4/1899	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY LEON LEVI		11. BIRTHPLACE (State or foreign country) NEW YORK, NEW YORK	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JACOB KAPLAN		14. MOTHER'S MAIDEN NAME BESSIE CHESLOCK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 577-07-5941		17. INFORMANT ADDRESS MRS. FLORENCE KAPLAN 3801 FORDLEIGH RD APT D	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) MYOCARDIAL INFARCTION		1 1/2 hours	
ANTECEDENT CAUSES		(B) ASHCRD -			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		PNEUMONIA, LEFT LUNG.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-26-65 to 6-14-65, that (I) (we) lost saw the deceased alive on 6-14-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr Ruth Willner		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-14-65	
23C. PHYSICIAN'S NAME (Type) RUTH WILLNER		23D. ADDRESS LEVIN DALE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6/15/65	24C. NAME of CEMETERY or CREMATORY BETH EL		24D. LOCATION (City, town, or county) (State) RANDALLSTOWN, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1965	25B. NAME OF REGISTRAR Robert E. Farkner	25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6281		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6281	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) BESSIE POLLACK			June 14 1965 10:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4015 KATHLAND AVENUE			A. STATE MARYLAND B. COUNTY 15-10		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 4015 KATHLAND AVENUE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12/1894	9. AGE (In years last birthday) 70	II Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME MAX METZ			14. MOTHER'S MAIDEN NAME GUSSIE LESTER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	17. INFORMANT ADDRESS MR. SAMUEL POLLACK 4015 KATHLAND AVENUE		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma Pancreas DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 1 year					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 19 64 to June 14 19 65 , that (I) (we) last saw the deceased alive on June 13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David I. Miller			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 14 1965
23C. PHYSICIAN'S NAME (Type) David I. Miller			23D. ADDRESS Linson Rd - Owings Mills, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6/16/65	24C. NAME OF CEMETERY or CREMATORY BETH TFILOH		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

65 6282		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6282	
BIRTH NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Nettie Kessler</u>		6/11/65 12 noon M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hosp</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-20</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
5. SEX <u>F</u> 6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>		8. DATE OF BIRTH <u>3-22-07</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>PT Home</u>		9. AGE (In years last birthday) <u>58</u>	
13. FATHER'S NAME <u>Harry Wasserman</u>		14. MOTHER'S MAIDEN NAME <u>Esther Friedberg</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-12-5204</u>		17. INFORMANT <u>Husband - Morris Kessler</u>	
18. <u>201X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Hodgkins Sarcma</u> (B) <u>1</u> (C) <u>6 mos.</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/10/65</u> to <u>6/11/65</u> , that (I) (we) last saw the deceased alive on <u>6/11/65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Miriam R. Cohen</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>6-11-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Miriam Cohen</u>		23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/13/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE HEBREW</u>	
24D. LOCATION <u>BALTIMORE</u>		<u>MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 16 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC.</u>	
				ADDRESS <u>6010 REISTERSTOWN RD</u>	

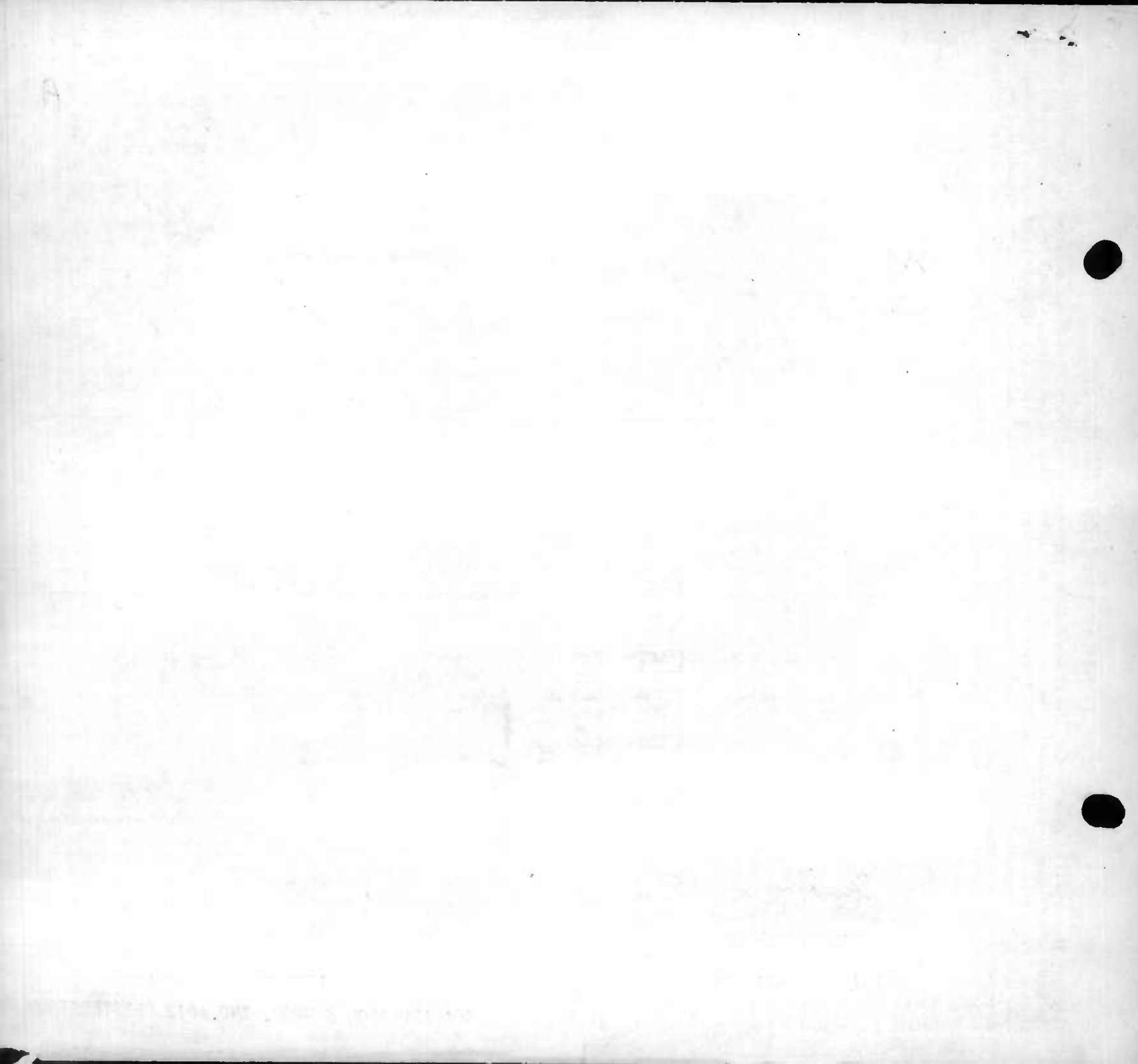
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FUNERAL DIRECTOR: IMPORTANT

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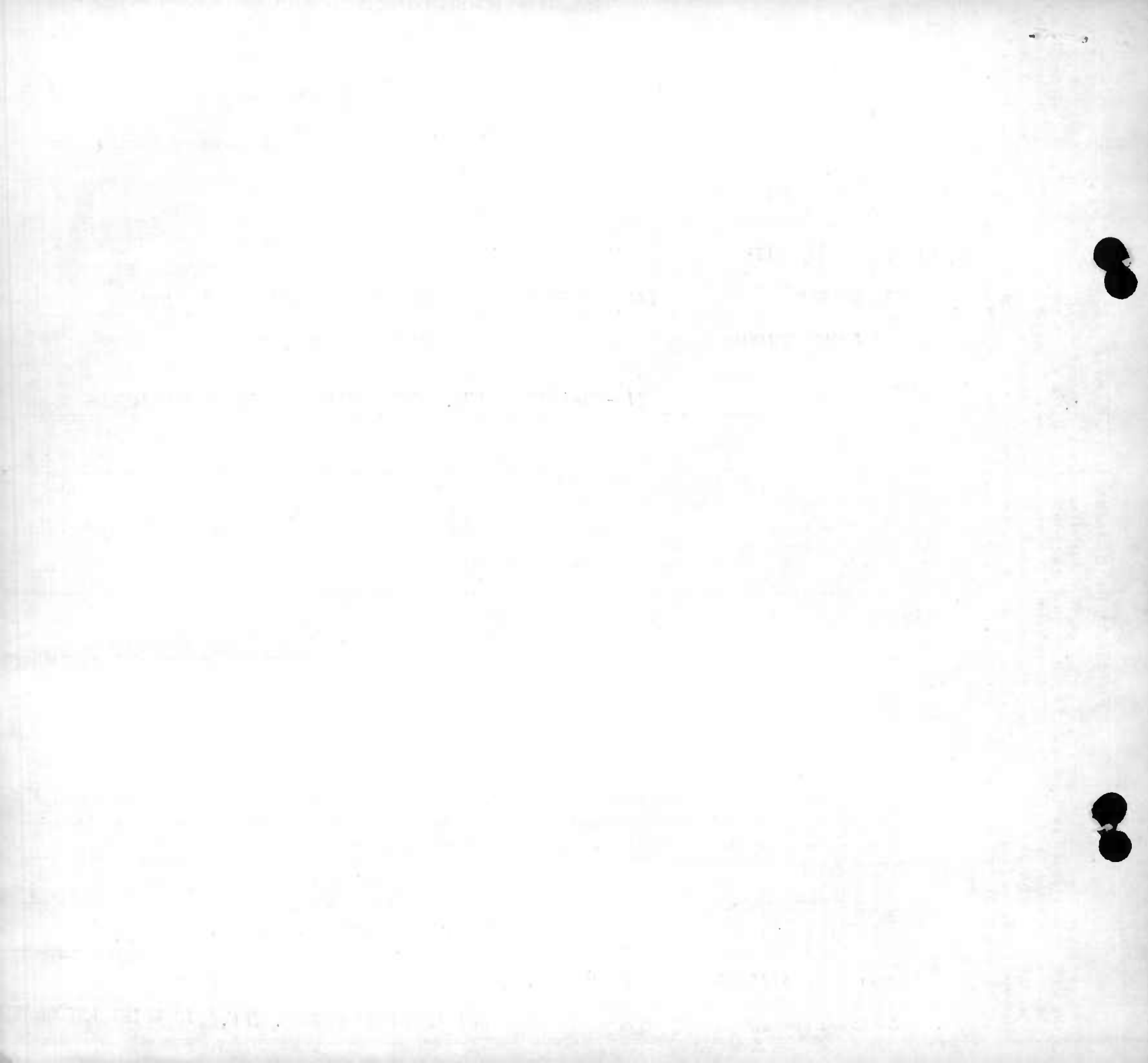
BIRTH NO. 65 6283		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6283	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Dr. Albert L. Hornstein</i>			2. DATE AND HOUR OF DEATH <i>6/11/65 11:20 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial</i>			A. STATE <i>Maryland</i> B. COUNTY <i>27-20</i>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
			D. STREET ADDRESS (If rural, give location) <i>6719 Westbrook Rd.</i>		
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH	9. AGE (In years) <i>75</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Physician</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>MEDICAL</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Mr. Louis Hornstein</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>daughter - Mrs. Norton Cordish</i>	
				ADDRESS <i>3226 Falls Rd.</i>	
18. I <i>177X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Cerebral Hemorrhage</i> DUE TO (B) <i>Thrombocytopenia</i> DUE TO (C) <i>Myelophthisis secondary to Prostatic CA.</i>		
			INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs.</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/10</i> 19 <i>65</i> to <i>6/11</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>6/11</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Miriam L. Cohen</i>				23B. DATE SIGNED <i>6/11/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Miriam Cohen</i>				23D. ADDRESS <i>Union Memorial</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>6/13/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>HEBREW FRIENDSHIP</i>	
24D. LOCATION <i>BALTIMORE</i>		24E. LOCATION <i>MARYLAND</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 16 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

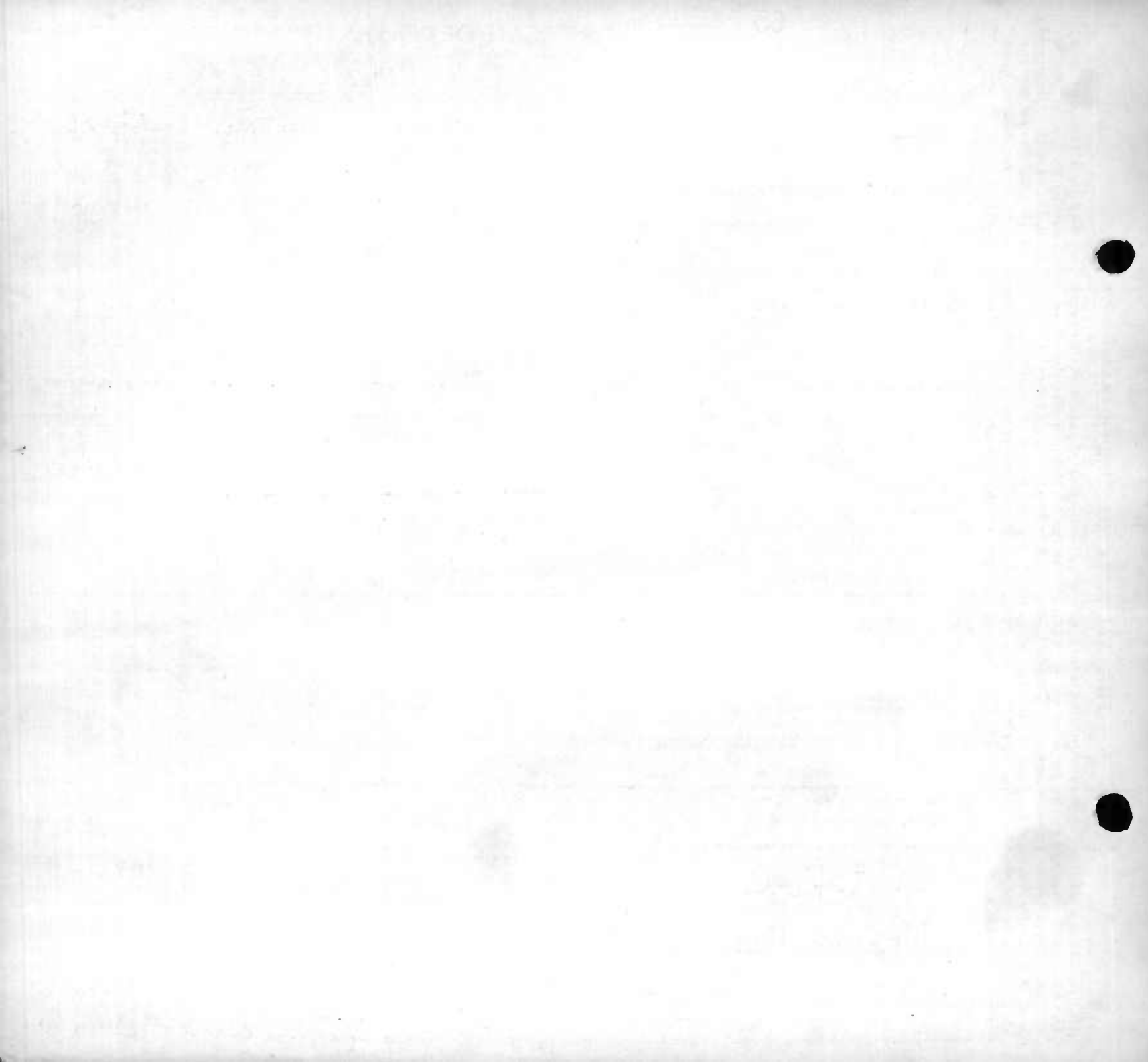
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 6284	
BIRTH NO. 65 6284		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Goldman, Herbert</u>		2. DATE AND HOUR OF DEATH <u>6-13-65</u> <u>6 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital</u>				A. STATE <u>Md.</u> B. COUNTY <u>2-7-17</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>2830 Oakley Ave.</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>10-15-15</u>	9. AGE (In years last birthday) <u>49</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAB DRIVER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>TAXI COMPANY</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK GOLDMAN</u>				14. MOTHER'S MAIDEN NAME <u>FANNIE SLAMOWITZ</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-03-1995</u>		17. INFORMANT ADDRESS <u>MRS. ROSE GOLDMAN 2830 OAKLEY AVENUE</u>			
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) <u>Pulmonary embolism</u> DUE TO		<u>immed</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Hypertensive C.V. Dis</u> DUE TO		<u>2 yrs.</u>	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initiate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 1963</u> to <u>June 1965</u> , that (I) (we) last saw the deceased alive on <u>June 11 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Irvin Sauber</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>6-13-65</u>			
23C. PHYSICIAN'S NAME (Type) <u>IRVIN SAUBER</u> M.D.		23D. ADDRESS <u>6905 Park Hgts No</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/15/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>HEBREW YOUNG MEN</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 16 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6285	
BIRTH NO. 65 6285		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) RICHARD BURNETT		2. DATE AND HOUR OF DEATH 6/13/65 16³⁰ A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE		D. STREET ADDRESS (If rural, give location) 4714 W. Raspe Avenue			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/8/1902	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Safety supervisor		10B. KIND OF BUSINESS OR INDUSTRY Works for freight Lines		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT WIFE 4714 W. Raspe Avenue	
18. 420.141260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction		CAUSE OF DEATH (A) Myocardial Infarction DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1-2 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Arteriosclerotic Cardiovascular Disease DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/12 1965 to 6/13 1965 , that (I) (we) last saw the deceased alive on 6/12 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. J. Kordon				23B. DATE SIGNED 6/13/65	
23C. PHYSICIAN'S NAME (Type) MELVIN JOEL KORDON		23D. ADDRESS Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/16/65		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION (City, town, or county) Baltimore		24E. STATE Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR 8521 Loch Raven B'	



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Willard Hamlett

2. DATE AND HOUR PRONOUNCED DEAD

June 13, 1965

4:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

814 N. Central Avenue

5. SEX

Male

6. RACE

NegRo

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED (SEP.)

8. DATE OF BIRTH

June 7, 1920

9. AGE (In years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MAIL CARRIER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTO. MD.

12. CITIZEN OF
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Edward Hamlett

14. MOTHER'S MAIDEN NAME

MATTIE SIMPSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

YES

WWII

16. SOCIAL
SECURITY NO.

17. INFORMANT

EDNA FOSTER

ADDRESS

934 N. CENTRAL AVE

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Probable hemochromatosis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
June 13, 196523A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

JUN 17 1965

23C. NAME of CEMETERY or CREMATORY

Balto. Mt. Cem.

23D. LOCATION

(City, town, or county)

(State)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 16 1965

24B. NAME OF REGISTRAR

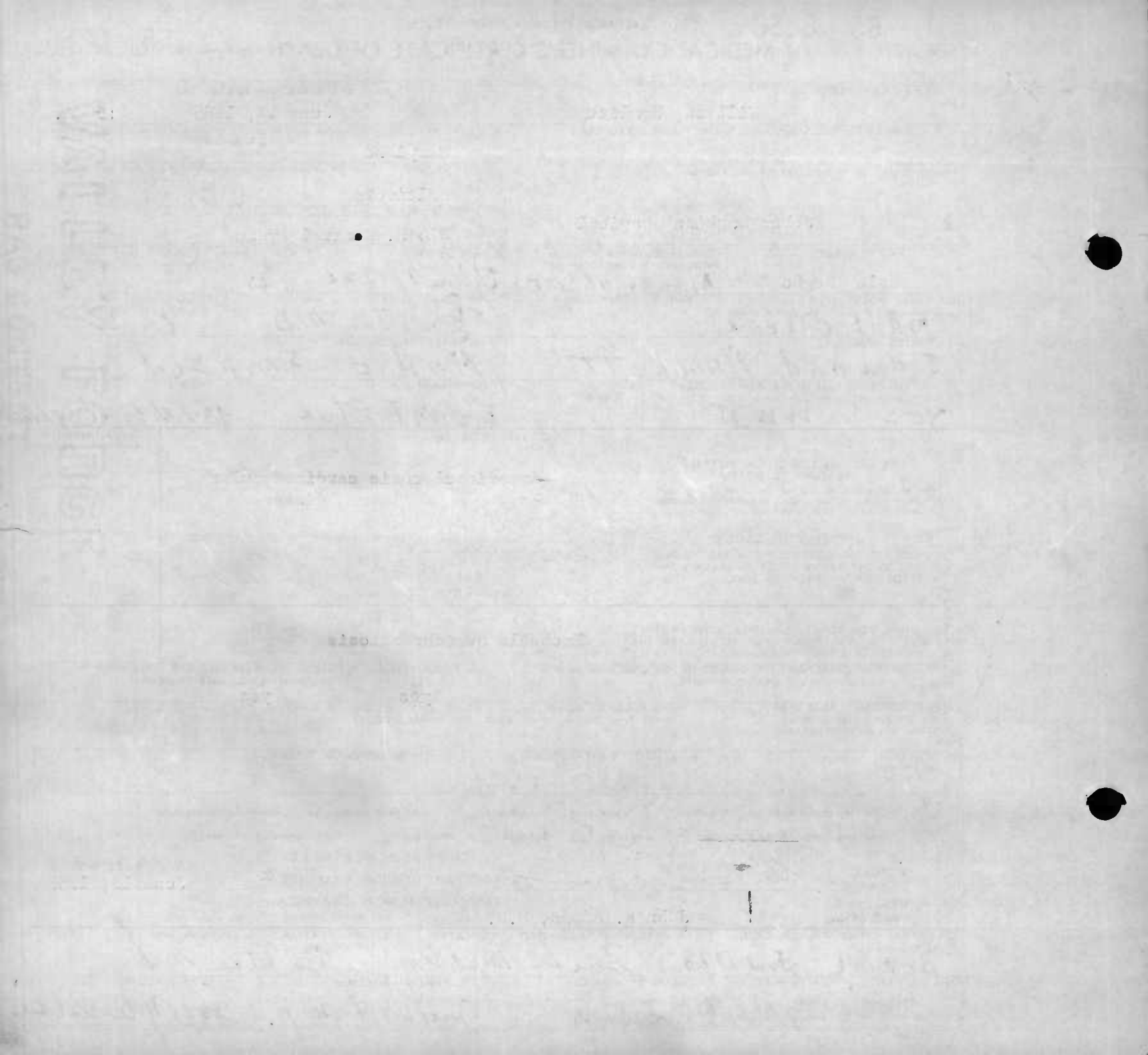
Robert E. Fairbank

24C. FUNERAL DIRECTOR

Joseph H. Locks Jr.

ADDRESS

1304 N. Central Ave.



1

65 6287

BALTIMORE CITY HEALTH DEPARTMENT

65 6287

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Mary Jackson

2. DATE AND HOUR PRONOUNCED DEAD June 12, 1965 10 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 204 N. Amity Street

5. SEX Female

6. RACE Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow

8. DATE OF BIRTH May 4, 1903

9. AGE (In years last birthday) 62

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

11. BIRTHPLACE (State or foreign country) Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Mack Brown

14. MOTHER'S MAIDEN NAME Elizabeth Burell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. 213-20-2428

17. INFORMANT Thomas Brown

ADDRESS 618 W. Saratoga St.

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Carcinomatosis

(A) DUE TO carcinoma of uterus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE John E. Adams M.D.

EXAMINER'S NAME (Type) John E. Adams, M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

ASSOCIATE MEDICAL EXAMINER

DATE SIGNED June 12, 1965

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE June 16/65

23C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.

23D. LOCATION (City, town, or county) (State) Balto. Md.

24A. DATE REC'D BY HEALTH DEPT. JUN 16 1965

24B. NAME OF REGISTRAR Robert E. Farley

24C. FUNERAL DIRECTOR Williams Funeral Home

ADDRESS 319 N. Schroeder St.

WATERBURY RECORD

60



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 6288BIRTH NO. 65 6288

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)JOHN TIGHE or John T. S. Tighe Jr.

2. DATE AND HOUR PRONOUNCED DEAD

June 14, 19659:10 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2720 Elliott Street

5. SEX

male

6. RACE

white7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed

8. DATE OF BIRTH

Sept. 29, 19039. AGE (in years
last birthday)61If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)Coal shute oper.

10B. KIND OF BUSINESS OR INDUSTRY

Balto. Construction

11. BIRTHPLACE (State or foreign country)

Philadelphia, Pa.12. CITIZEN OF
WHAT COUNTRY?U.S.A.

13. FATHER'S NAME

John Tighe

14. MOTHER'S MAIDEN NAME

Mary Owens15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)No16. SOCIAL
SECURITY NO.218 07 8530

17. INFORMANT

ADDRESS

Lillian Sokolski 4306 Valley View Ave. # 6

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?Yes21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)John E. Adams

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-15-6523A. BURIAL CREMATION,
REMOVAL (Specify)Burial

23B. DATE

6/17/65

23C. NAME of CEMETERY or CREMATORY

Schwartz's Cemetery

23D. LOCATION

(City, town, or county)

(State)

O'donnell St. Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 16 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

The Dippel Brothers Inc. Lombard St.1800 E.

Two

John A. T. 1900

2000

1900

1900

1900

1900

1900

1900

1900

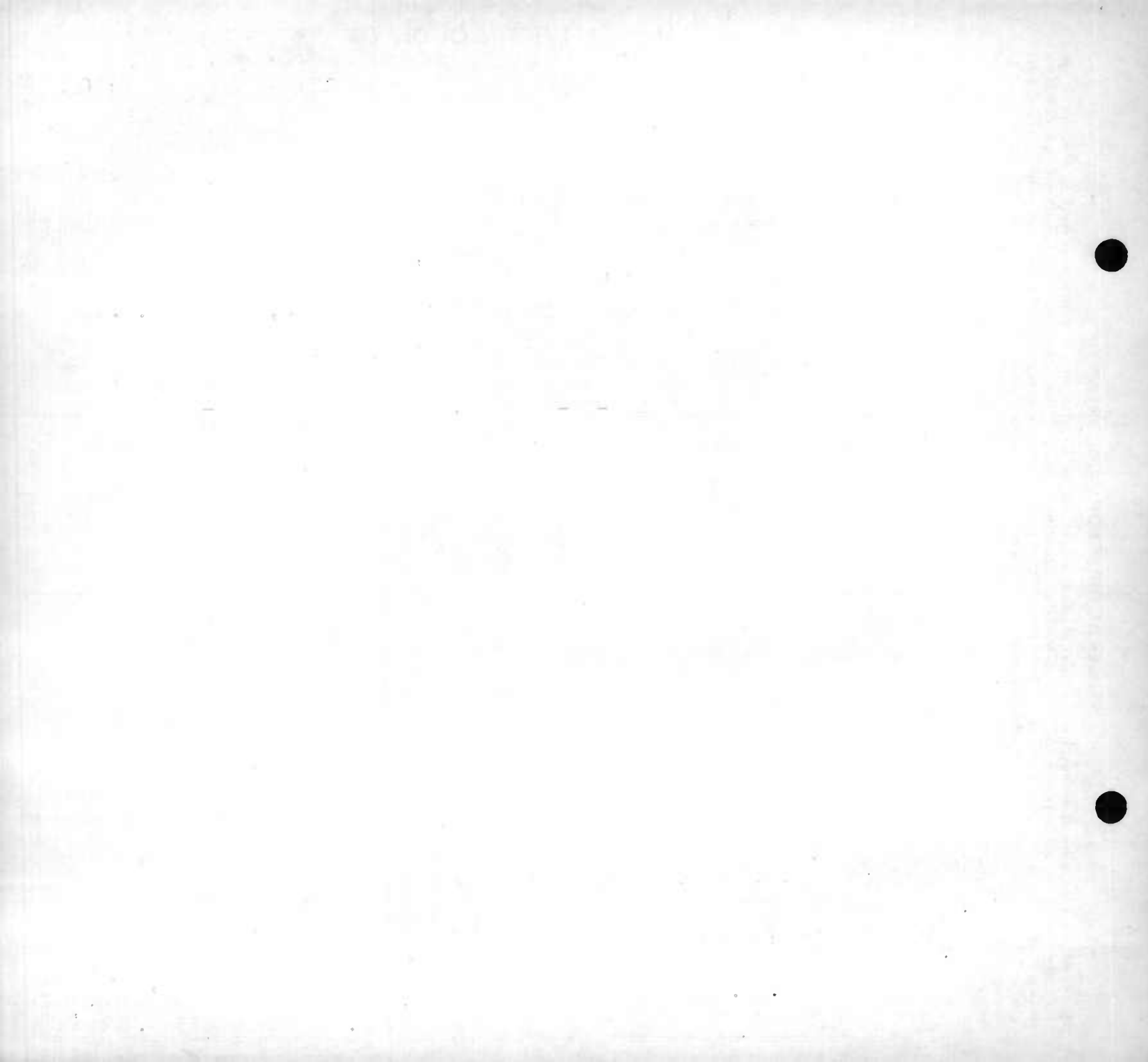
1900

1900

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6289	
BIRTH NO. 65 6289		CERTIFICATE OF DEATH		Registered No. 65 6289	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William Henry Booker		2. DATE AND HOUR OF DEATH June 13, 1965 8:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-04		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1903 Ruxton Ave		D. STREET ADDRESS (If rural, give location) 1903 Ruxton Ave			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH June 1, 1876	9. AGE (In years last birthday) 89	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		10B. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (State or foreign country) Prince Edward Co., Va	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lewis Henry Booker		14. MOTHER'S MAIDEN NAME Harriett Fleshman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-05-5888		17. INFORMANT Mr. Fancell Booker Sr- 2927 Windsor Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DUE TO Anterior Cerebral Artery Vascular Disease		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from April 30 1965 to June 13 1965, that (I) (we) last saw the deceased alive on June 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE William H. Watts M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) William H. Watts		23D. ADDRESS 515 N. Dr. 1/10/65			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6.17.65		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 16 1965		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR Herbert E. Nutter 3035 W. North Ave					



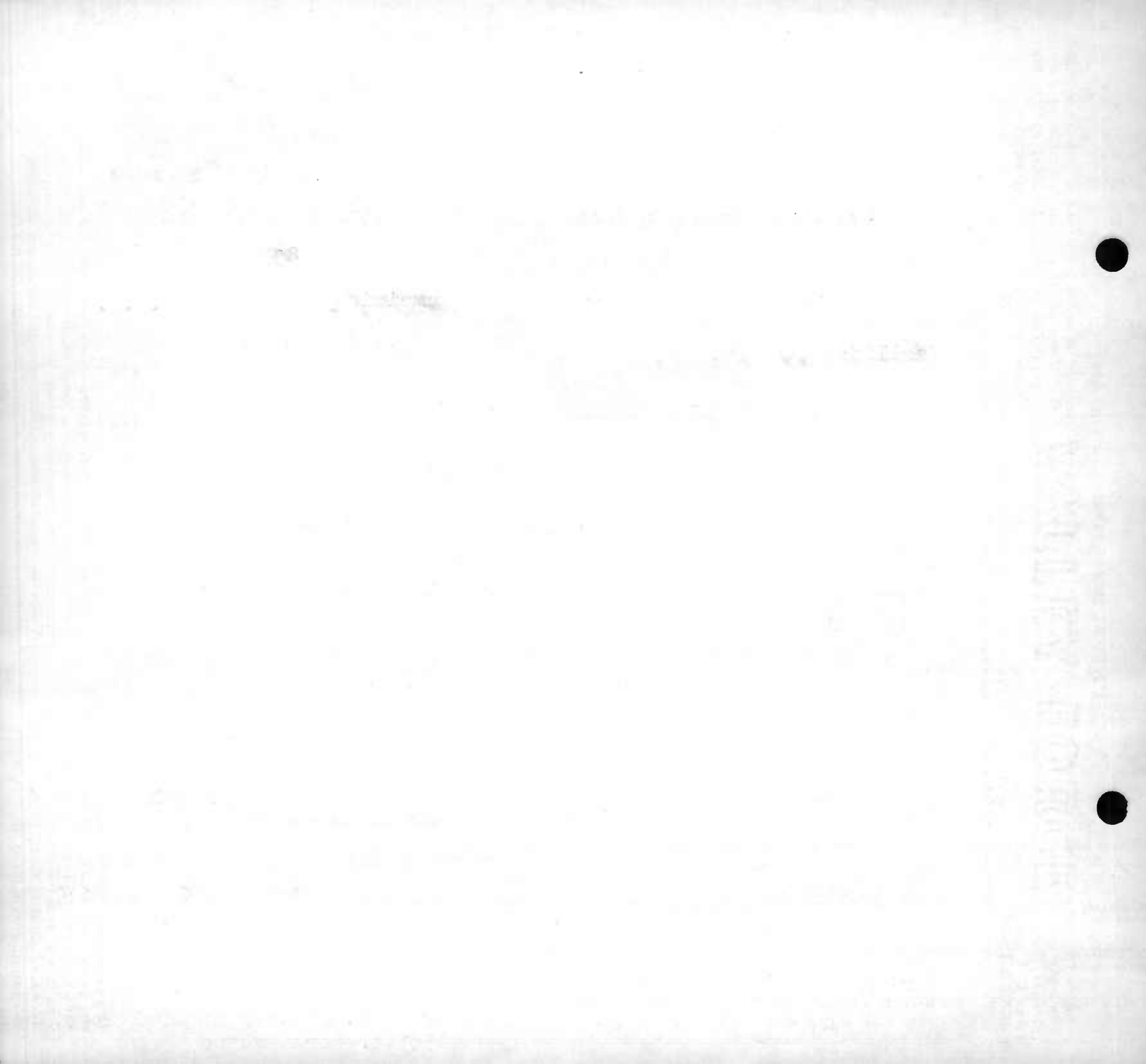
65 6290		BALTIMORE CITY HEALTH DEPARTMENT		65 6290	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD			
CALVIN BURRELL		June 10, 1965 1:45 p M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE Maryland			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY			
University Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
		Baltimore 13-03			
D. STREET ADDRESS (If rural, give location)		2512 Madison Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
male	colored	Married	April 10, 1902	63	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Elevator Operator		Apartment Bldg.		Baltimore Maryland	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Joseph David Burrell		Edmonia Curry			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		214-01-8064		Ethel Burrell-2512 Madison Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
150X I		Carcinoma of the esophagus			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		6/11/65		Mt. Auburn Cemetery	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
JUN 16 1965		Robert E. Farley, M.D.		Hutter Funeral Home-3035 W. North Ave.	

WALLEN POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6291				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6291	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Alexander Banda.</u>				2. DATE AND HOUR OF DEATH <u>6-12-65.</u> <u>8:04 A.M.</u>			
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>24-01</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Baltimore General Hosp.</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> # <u>21230</u>			
				D. STREET ADDRESS (If rural, give location) <u>1411 Haubert St.</u>			
5. SEX <u>M.</u>	6. RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>3/3/1882</u>	9. AGE (In years lost birth) <u>83</u>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>B & O Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Rumainia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Vasilija Banda</u>				14. MOTHER'S MAIDEN NAME <u>Marija Milivoj</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. -----		17. INFORMANT ADDRESS <u>Charles Banda 511 Gun Road</u>	
18. <u>420.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Ante Pulmonary Edema</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Heart Disease</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES.</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from <u>6-11</u> 19 <u>65</u> to <u>6-12</u> 19 <u>65</u> , that the (we) last saw the deceased alive on <u>6-12</u> 19 <u>65</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6-12-65.</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. _____					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/16/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Cross Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Anna Arundel, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 16 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue</u>			



B-634

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 6292		65 6292		65 6292	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Frederick Bradley		June 13, 1965		7:00 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		Maryland Baltimore		26-09	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
Male	White			Widowed	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
STATE ROADS				Kentucky	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
DECEASED		DECEASED		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				RECORDS: BCH: 4940 Eastern Avenue #21224	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Intestinal Obstruction		5 Days	
ANTECEDENT CAUSES		(B) Metastatic Disease		2 Months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from June 3, 19 65 to June 13, 19 65, that (I) (we) last saw the deceased alive on June 13, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
J. B. Zachary				June 13, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. J. B. Zachary		4940 Eastern Avenue Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		6/17/65		MT. CARMEL BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 16 1965		E. W. Hoffmann		3218 HUDSON ST.	

STATE ROAD
DECEASED

DEC 1912

Wm. H. H. 3518
Wm. H. H. 3518
Wm. H. H. 3518

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

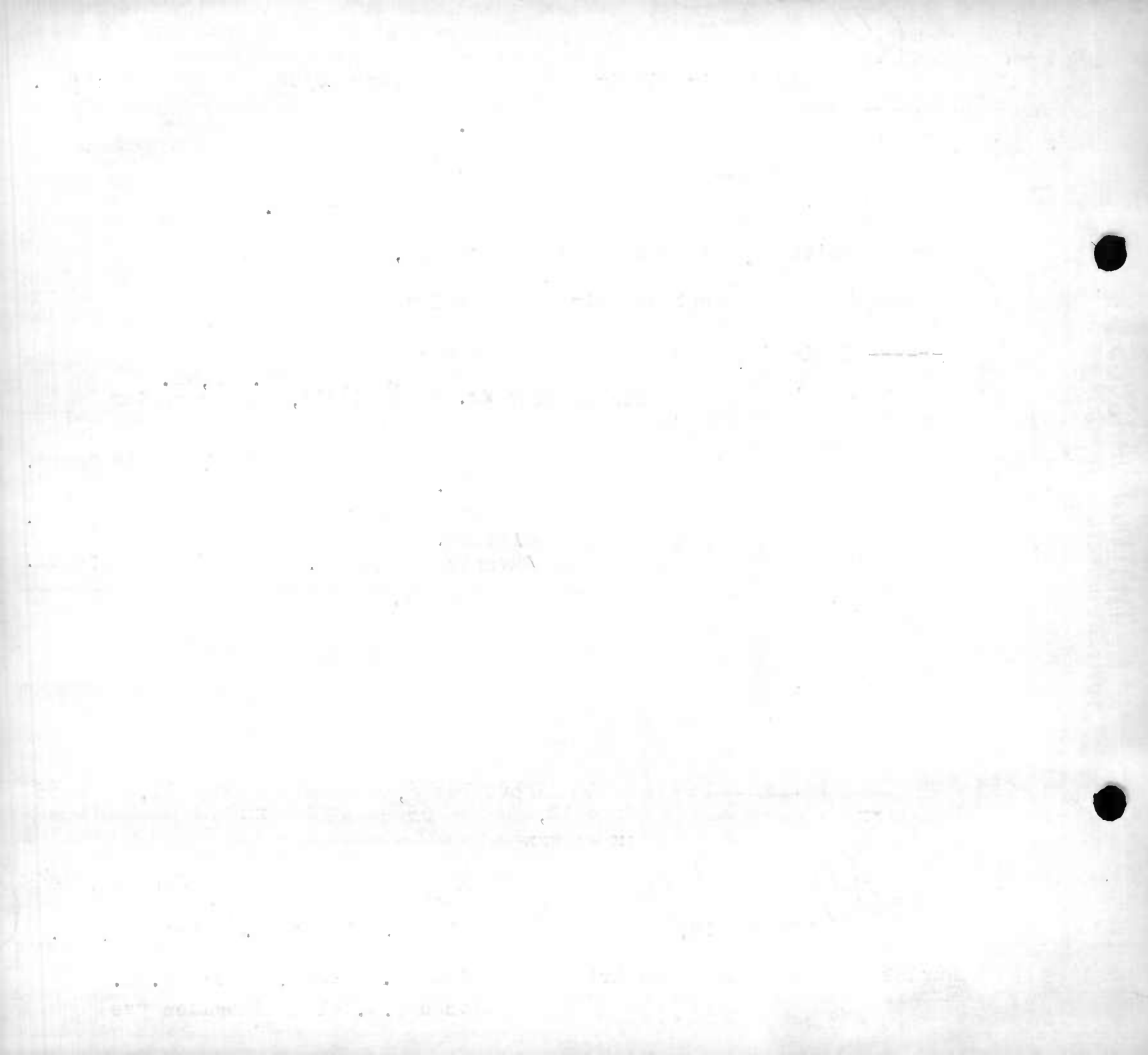
BIRTH NO. 65 6293				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6293	
M.E. CASE NO. XXXXXX				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Pinson, Henry S.				2. DATE AND HOUR OF DEATH June 15, 65		7:55 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Saint Agnes Hospital Caton & Wilkens Ave. #21229				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 28-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1142 Cooks Lane #29			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/19/05		9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman		10B. KIND OF BUSINESS OR INDUSTRY Penna Railroad		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Pinson		14. MOTHER'S MAIDEN NAME Unknown		17. INFORMANT Balto. 29, Md. Mrs. Violet Pinson, 1142 Cooks Lane			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute massive Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) state the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 6-15-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-15-65 to 6-15-65 at 7:55 AM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/15/65	
23C. PHYSICIAN'S NAME (Type) [Signature]				23D. ADDRESS M.D. Caton & Wilkens Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/18/65		24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Balto. 29, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR itzke 7.10.4101 Edmondson			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

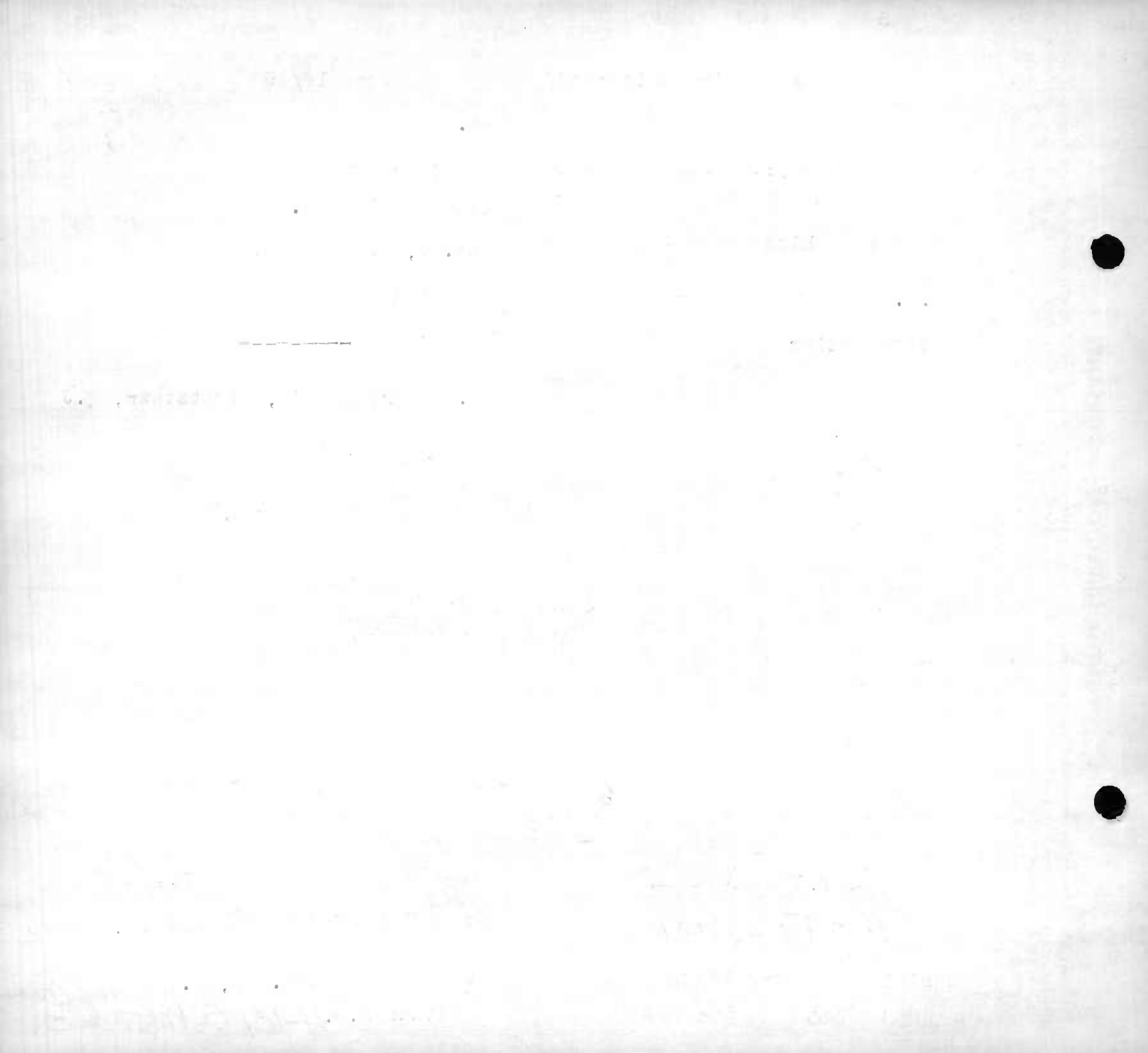
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. _____	
BIRTH NO. 65 6294				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Edgar Bain Riggin			2. DATE AND HOUR OF DEATH June 13/65 10:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 28-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4602 Coleherne Rd.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH July 16, 1875	9. AGE (In years last birthday) 89	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Boat Captain		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME -----Riggin			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219 28 6407		17. INFORMANT (SON) Balto. 29, Md. ADDRESS Wm. Edgar Riggin, 710 Winans Way	
18. 561.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Strangulated left inguinal hernia. (B) Arteriosclerotic heart disease. (C) Chronic Emphysema.		INTERVAL BETWEEN ONSET AND DEATH 12 hours. 8 years. 8 years.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6/16/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 6, 1957 to June 13, 1965 , that (I) (we) last saw the deceased alive on June 12, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.					
23A. SIGNATURE Alfred Cole				23B. DATE SIGNED June 14, 1965	
23C. PHYSICIAN'S NAME (Type) Alfred Cole,		23D. ADDRESS M.D. 136 S. Hilton St. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/16/65		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Pk. Dorsey, Howard Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Witzke F.D. 4101 Edmondson Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6295	
BIRTH NO. 5		65 6295		CERTIFICATE OF DEATH	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Katherine Weisengoff		
2. DATE AND HOUR OF DEATH June 14/65			10. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 19-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 23 D. STREET ADDRESS (If rural, give location) 1514 Hollins St.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Nov. 9, 1897	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Steve Koziar			14. MOTHER'S MAIDEN NAME Christine		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Robert LaBrie, Wrightstown, N.J		
18. 420.14-260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus Hypertension			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 9/16/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 6/7/1949 to 6/14/1965 , that (I) (we) last saw the deceased alive on 6/16/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L. P. Friedman			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 9/16/65
23C. PHYSICIAN'S NAME (Type) L. P. FRIEDMAN			23D. ADDRESS M.D. 1319 LIGHT ST. BALTIMORE, MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE June 17/65	24C. NAME OF CEMETERY or CREMATORY New Cathedral	24D. LOCATION (City, town, or county) (State) Balto. 29, Md.		
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1965		25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR Witzke F.D.		ADDRESS 4101 Edmondson

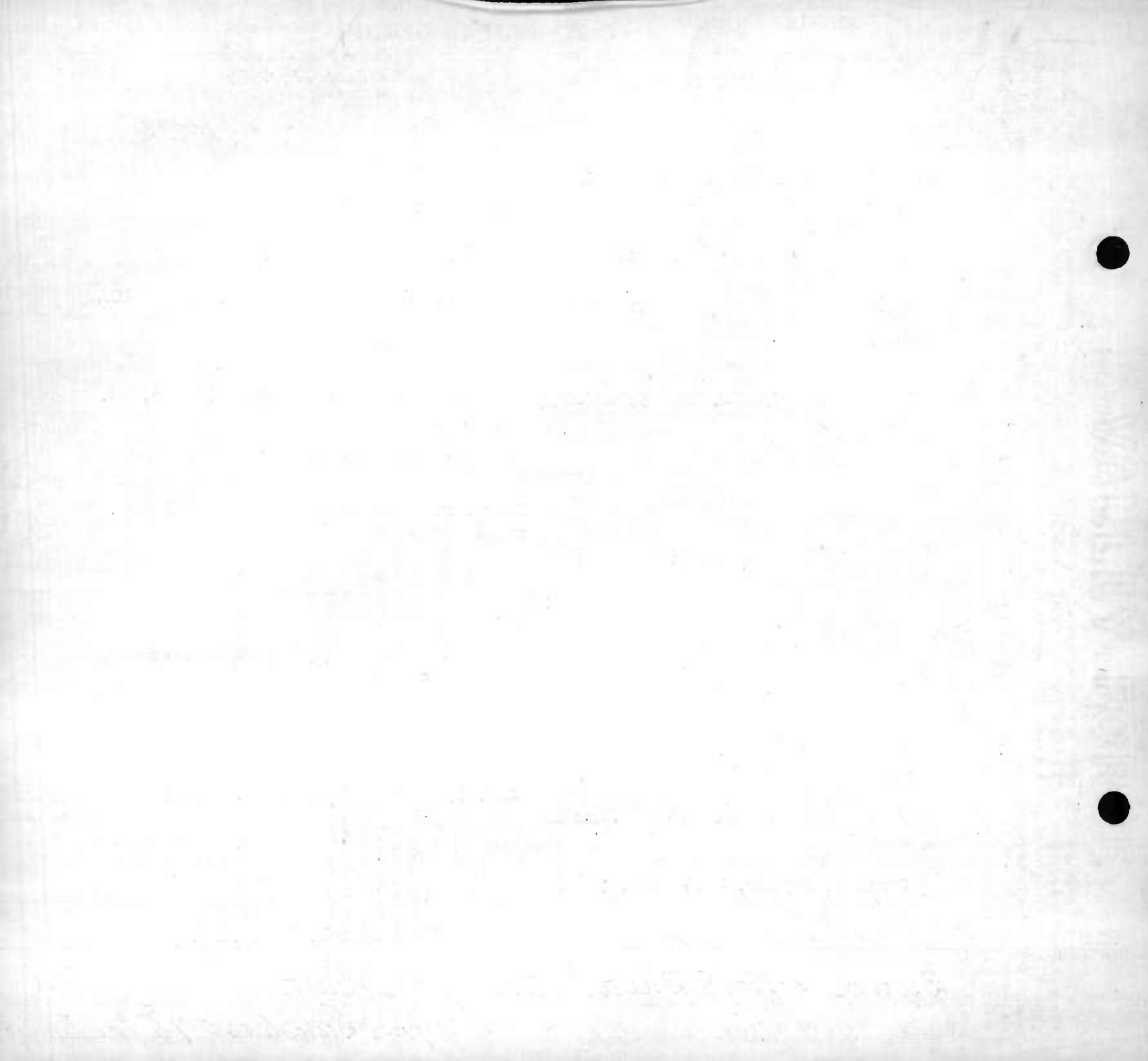


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 6296					REGISTERED NO. 65 6296				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) PERLE LAVERN JOHNSON					2. DATE AND HOUR OF DEATH June 14, 1965 6 A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pa. B. CDUNTY V-35				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st St.					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Philadelphia				
					D. STREET ADDRESS (If rural, give location) 1032 Spruce Street				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH 12/3/99	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook			10B. KIND OF BUSINESS OR INDUSTRY Seafarer		11. BIRTHPLACE (State or foreign country) Michigan			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fred Johnson					14. MOTHER'S MAIDEN NAME May Stark				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USA 1917-1920			16. SOCIAL SECURITY NO. 551-26-2942		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.				
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Multiple pulmonary emboli					Hours				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma of stomach with DUE to carcinomatosis					3 yrs.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from Jan. 13 1965 to June 14 1965 , that (1) (we) last saw the deceased alive on June 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE James E. Taylor, Jr., Surgeon (R)					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 6/14/65	
23C. PHYSICIAN'S NAME (Type) James E. Taylor, Jr.					23D. ADDRESS US PHS Hospital, Balto, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-18-65		24C. NAME OF CEMETERY OR CREMATORY Balto National Cem. Balto Md.		24D. LOCATION (City, town, or county) (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Rayner Sanders		25D. ADDRESS 276 Preston St			



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H-251

65 6297 BALTIMORE CITY HEALTH DEPARTMENT 65 6297

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
SAMUEL H. HIGGINBOTHAM		6/11/65 6:35 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland B. COUNTY	
Union Memorial Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-84	
D. STREET ADDRESS (If rural, give location)		328 Worsley St.	
5. SEX male	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 12-23-1896
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 68
13. FATHER'S NAME Charles Higginbotham		11. BIRTHPLACE (State or foreign country) Virginia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Betty P.	12. CITIZEN OF WHAT COUNTRY?
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Emma Higginbotham 328 Worsley St.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
(A) Carcinoma of larynx DUE TO			
(B) DUE TO			
(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) no
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/11/65	
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	6-15-65	Arctus Memorial Park	Baltimore Md
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JUN 16 1965	Robert E. Fairbank	Rayner Sanders	2175 Preston St.

VALLEY FORT

100-100-100

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65 6298

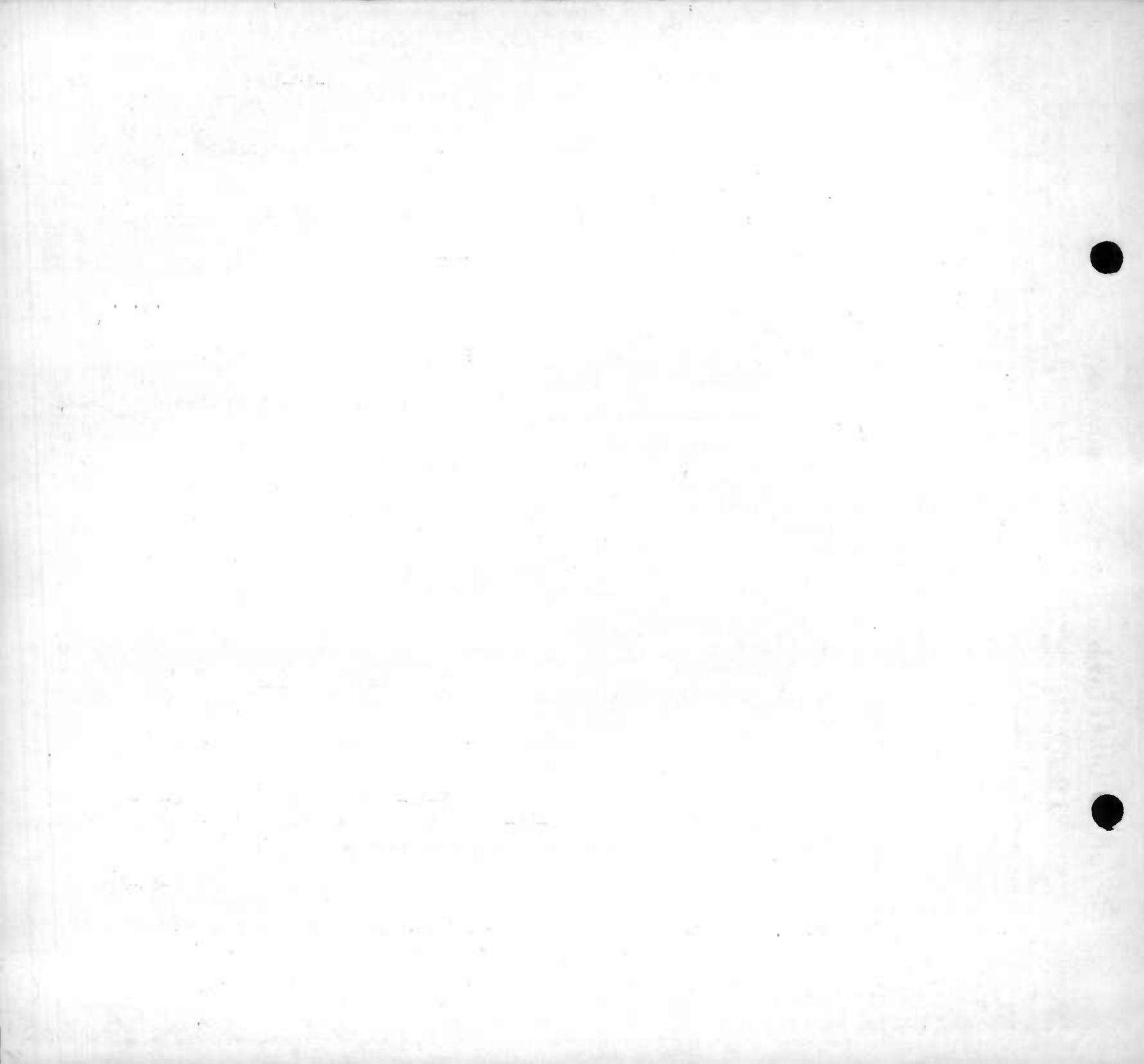
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 6298

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 6298		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6298	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Maggie Carter				6-10-1965		2:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				Maryland 26-12			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				4940 Eastern Avenue 21224			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	
Female	Negro	Widowed	4-7-1880	84			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
House Wife			Virginia		U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
David Cole			Berque Cole				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
					Records: BCH-4940 Eastern Avenue 21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) Pulmonary Embolism			
				DUE TO			
ANTECEDENT CAUSES				(B) Gangrene 5th. right Toe			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 5-22-19 63 to 6-10-19 65, that (I) (we) last saw the deceased alive on 6-10-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Dr. H. Rathbun						6-10-1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. H. Rathbun				4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6-14-65		Mt Calvary Cem A.A.C.		Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 16 1965		Robert E. Farley		Rayner Sanders		217 E. Preston St	



BIRTH NO. 65 6299		BALTIMORE CITY HEALTH DEPARTMENT		65 6299	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD	
WILLIAM GATEWOOD				6-14-65 10:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland	
CHURCH HOME & HOSPITAL - DOA				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
				D. STREET ADDRESS (If rural, give location) 915 E. Fayette Street	
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married (Sep)	8. DATE OF BIRTH 2-27-12	9. AGE (In years last birthday) 47	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Gatewood			14. MOTHER'S MAIDEN NAME M.G. Y.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII			16. SOCIAL SECURITY NO. 420-14-0150		
			17. INFORMANT Irene Johnson 19N. Bentalou St		
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
(A) Pulmonary emphysema with cor pulmonale					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		PETER W. RIECKERT, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)	
Burial		6-18-65	Bethel Natl. Cem.	Baltimore, Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
JUN 16 1965		Robert E. Farley, M.D.		George A. Kilar 1348 N. Calhoun St.	

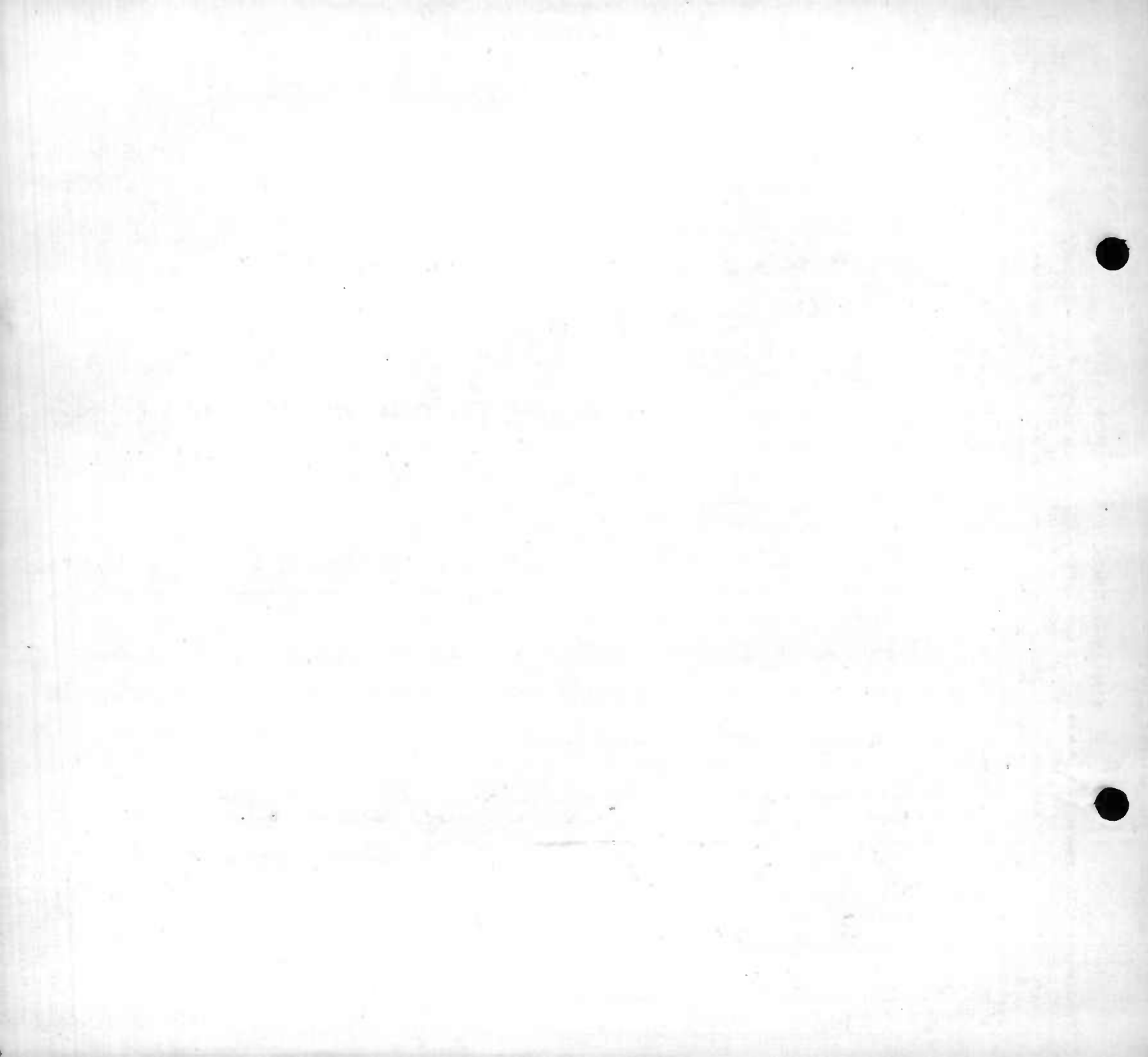
WALLER EDDIE

to land a lot

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

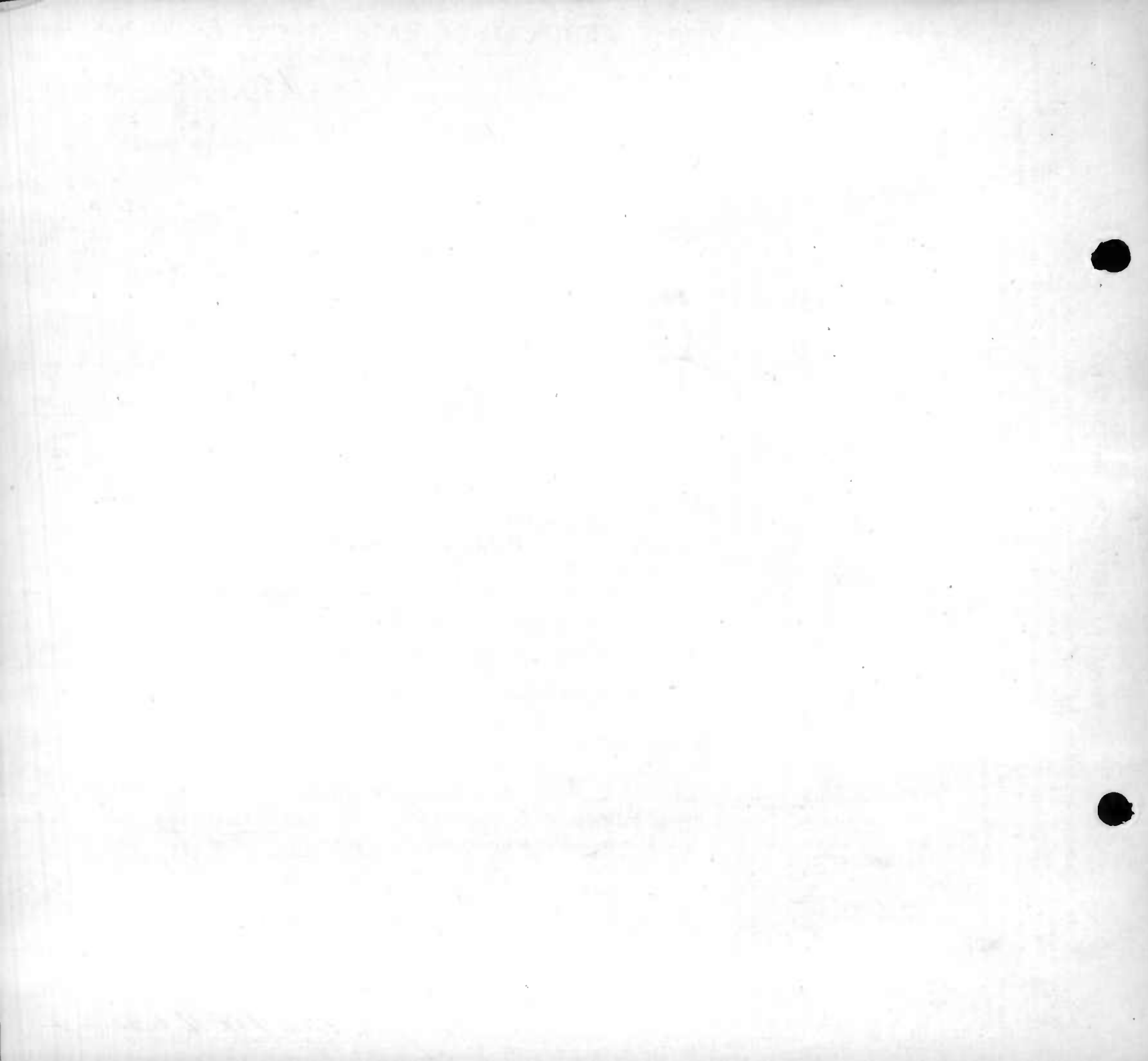
BIRTH NO. 65 6300		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6300	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Helen McGowan		JUNE 14, 1965 6 ⁰⁰ P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland 19-01		C. CITY OR TOWN (If outside city limits, write RURAL and give Township)	
1420 W. Franklin St.		Baltimore		D. STREET ADDRESS (If rural, give location)	
1420 W. Franklin St.		1420 W. Franklin St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	Negro	Widowed	March 31, 1907	68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Domestic				Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		James Johnson		Estella Chase	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		212-32-2020		Gertrude Rozier 1420 W. Franklin St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Heart failure		4 1/2 weeks	
		(B) DUE TO			
		(C) Carcinomatosis		4 1/2 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work Not While At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1, 1965 to June 14, 1965, that (I) (we) lost saw the deceased alive on June 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (They) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. Med. Director Staff Phys.		23B. DATE SIGNED	
E. J. KINGTON				6/16/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
E. J. KINGTON		841 Harlem Ave Balt			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-18-65		Arbutus Mem. PK Arbutus, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 16 1965		Robert E. Falcus		George A. Nelson 1348 N. Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be given by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6301	
BIRTH NO. 65 6301		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN W. JAMES		2. DATE AND HOUR OF DEATH JUNE 15, 1965 6:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSP.		A. STATE MARYLAND B. COUNTY 19-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1732 W. LEXINGTON ST.			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 3/19/26	9. AGE (In years last birthday) 39	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S. CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME HENRY JAMES		14. MOTHER'S MAIDEN NAME MINNIE ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Maple James 1735 W. Lexington St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 443X I		CAUSE OF DEATH (A) INTRAVENTRICULAR HEMORRHAGE DUE TO INTRACRANIAL HEMORRHAGE (B) CARDIAC HYPERTROPHY DUE TO HYPERTENSION (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 14 1965 to JUNE 15 1965 that (I) (we) lost saw the deceased alive on JUNE 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE P E B RION M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 15, 1965	
23C. PHYSICIAN'S NAME (Type) P E B RION M.D.		23D. ADDRESS F 5 H			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/16/65		24C. NAME of CEMETERY or CREMATORY Wm Calvary Cem	
24D. LOCATION (City, town, or county) (State) ANNAPOLIS Co. MD		25A. DATE REC'D BY HEALTH DEPT. JUN 16 1965		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR ADDRESS Stony A. Hill 158 N. Calver St					



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G-570

65 6302

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65 6302

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) AMOS GAINES		2. DATE AND HOUR PRONOUNCED DEAD 6-13-65 4:55 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD PROVIDENT HOSPITAL - DOA		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1374 N Fremont Avenue 21217	
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 5-7-1902
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 63
13. FATHER'S NAME Earley Gaines		14. MOTHER'S MAIDEN NAME Sally Martin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 22-18-3845	
17. INFORMANT John Gaines 544/16th Ave		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6/17/65	
23C. NAME OF CEMETERY or CREMATORY Not known		23D. LOCATION (City, town, or county) (State) Baltimore, Md.	
24A. DATE REC'D BY HEALTH DEPT. JUN 16 1965		24B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
24C. FUNERAL DIRECTOR George A. Kline		ADDRESS 1340 N. Allen St	

WALLLEY FORCE

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WALLLEY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6303		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6303	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MRS. LILLIAN SPELLMAN		2. DATE AND HOUR OF DEATH JUNE 14, 1965 2:00 P1 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CHURCH HOME AND HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 13-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3710 CHESTNUT AVE.			
5. SEX F	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH July 17, 1904	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME CHARLES RIGGS		14. MOTHER'S MAIDEN NAME LILLIAN FRAZIER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-466336		17. INFORMANT DORIS WAGNER 3710 Chestnut Ave. Bal 11	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Congestive heart failure DUE TO (B) Carcinoma of the lung, left DUE TO (C) Cerebrovascular accident		INTERVAL BETWEEN ONSET AND DEATH 15 hrs. months 3 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 30 19 65 to June 14 19 65, that (I) (we) last saw the deceased alive on June 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Manuel J. Tan		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) MANUEL J. TAN		23D. ADDRESS M.D. CHURCH HOME AND HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6/17/65	24C. NAME of CEMETERY or CREMATORY LORRAINE PARK		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JUN 16 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Paul E. Chenoweth 3617 Chestnut Ave.	

Thomas J. Turner

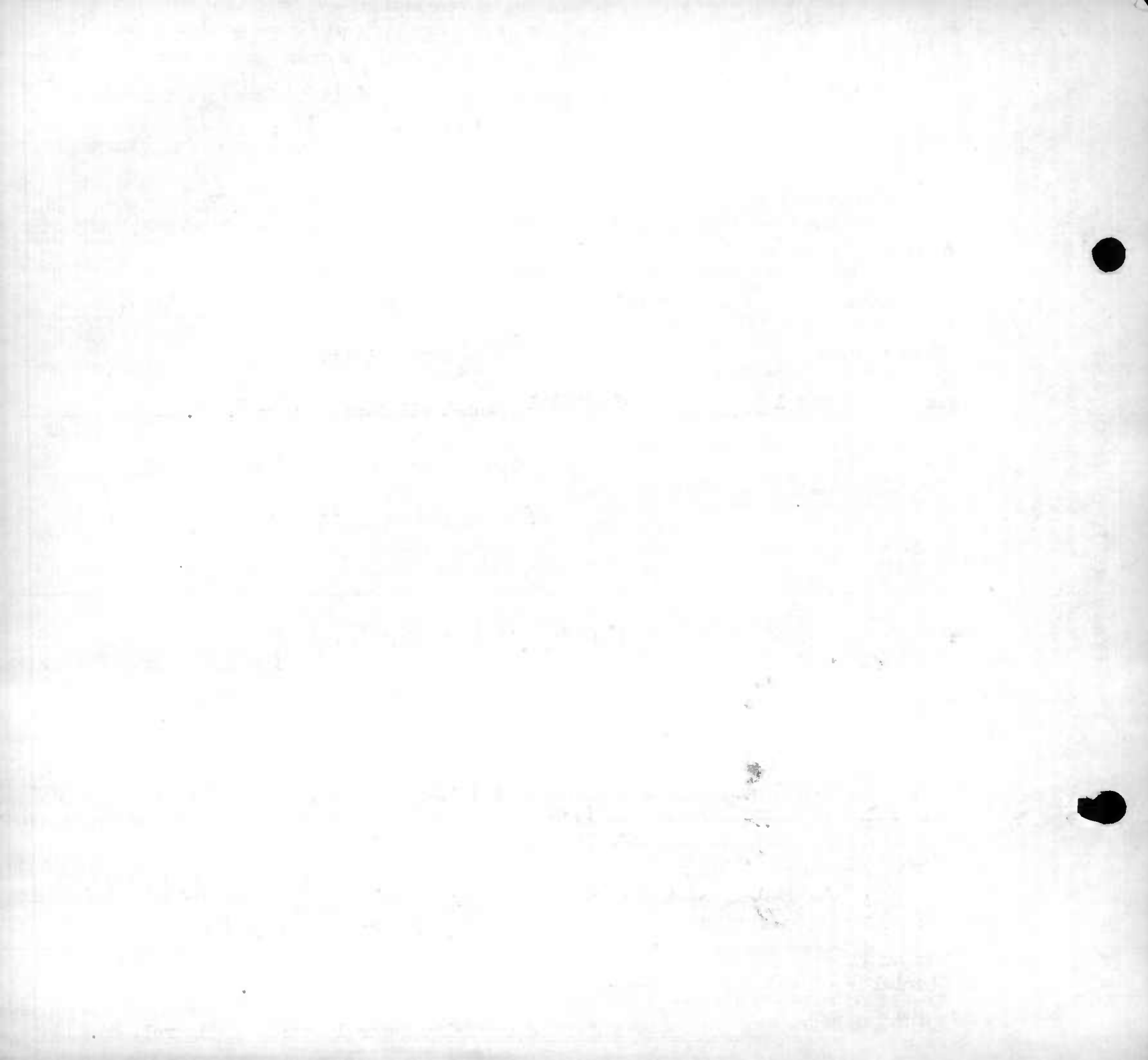
1/10/10 CORNELL PARK, ILLINOIS

in C. C. & T. J. Turner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6304		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6304	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charles Green		2. DATE AND HOUR OF DEATH 6/13/65 12:12 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Howard		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Laurel	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University		D. STREET ADDRESS (If rural, give location) Route 5 Box 27		63-00	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 5/22/88	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10B. KIND OF BUSINESS OR INDUSTRY general		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas Green		14. MOTHER'S MAIDEN NAME Sarah Gibson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. 705 10 3171		17. INFORMANT RFD 1 Rachel Williams Laurel, Md.	
18. 420.1X-1002.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cardiogenic shock		CAUSE OF DEATH (A) DUE TO Myocardial infarction - suspected		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHF, pulmonary T. L.		(B) DUE TO		(C)	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19C. DATE OF OPERATION		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/12 19 65 to 6/13 19 65 , that (I) (we) last saw the deceased alive on 6/13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jonathan Luck		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/13/65	
23C. PHYSICIAN'S NAME (Type) Robert E. Faly...		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 6/16/65		24C. NAME of CEMETERY or CREMATORY Beacons Chapple	
24D. LOCATION (City, town, or county) (State) Laurel, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 16 1965		25B. NAME OF REGISTRAR Robert E. Faly...	
25C. FUNERAL DIRECTOR Selby Funeral Home		ADDRESS Laurel, Md.			



LS: 43-86-19

L-320

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 6305

BIRTH NO.

65 6305

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Catherine Ludwig

2. DATE AND HOUR OF DEATH

June 15, 1965

2:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

RURAL: Dundalk

D. STREET ADDRESS (If rural, give location)

1858 Marshall Road #21222

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed

8. DATE OF BIRTH

1-25-10

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Counter work, White, Coffee Pot Co.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

William Bateman

14. MOTHER'S MAIDEN NAME

Concetta Coniconion

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL
SECURITY NO.

216-20-8582

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #21224

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenio, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION lost.

CAUSE OF DEATH

(A)
DUE TOUremia 2° to Bilateral
Ureteral Obstruction(B)
DUE TO

Carcinomatosis of Abdomen

(C)

INTERVAL BETWEEN
ONSET AND DEATH

5 Days

1 Year

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 13, 19 65 to June 15, 19 65,
that (I) (we) lost saw the deceased alive on June 15, 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

C.C.J. Carpenter

M.D.

Attending
Phys. ☐Med.
Director ☐Stall
Phys. ☒

23B. DATE SIGNED

June 15, 1965

23C. PHYSICIAN'S
NAME (Type)

Dr. C. C. J. Carpenter

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland #24

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

June 18-1965 Baltimore National

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Frederick Rd. Catonsville, Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 16 1965

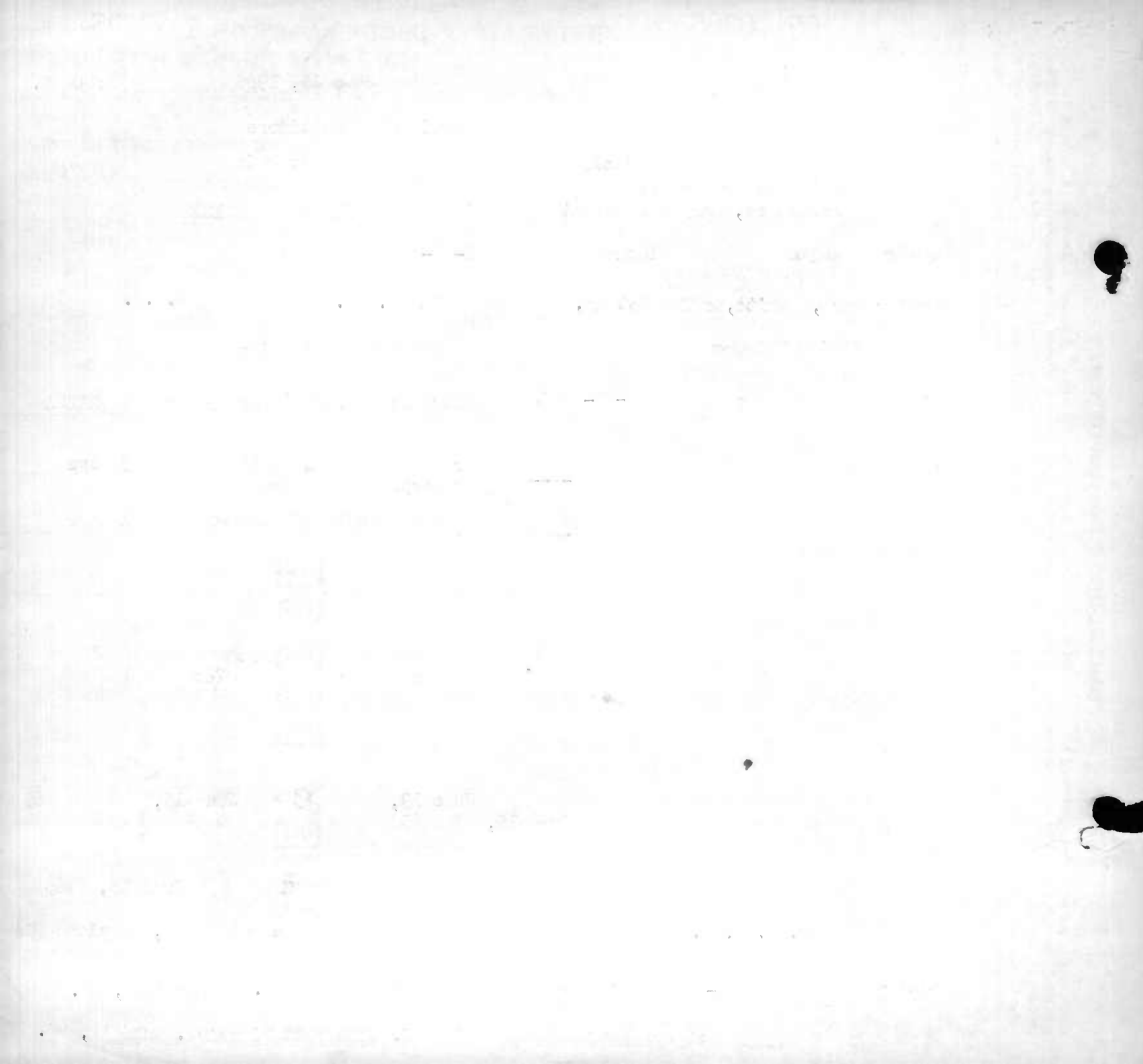
25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

ADDRESS

JOHN J. DUDA 7922 Wise Ave. Dundalk, Md. 22



LS: 43-65-25
E-25

65 6306

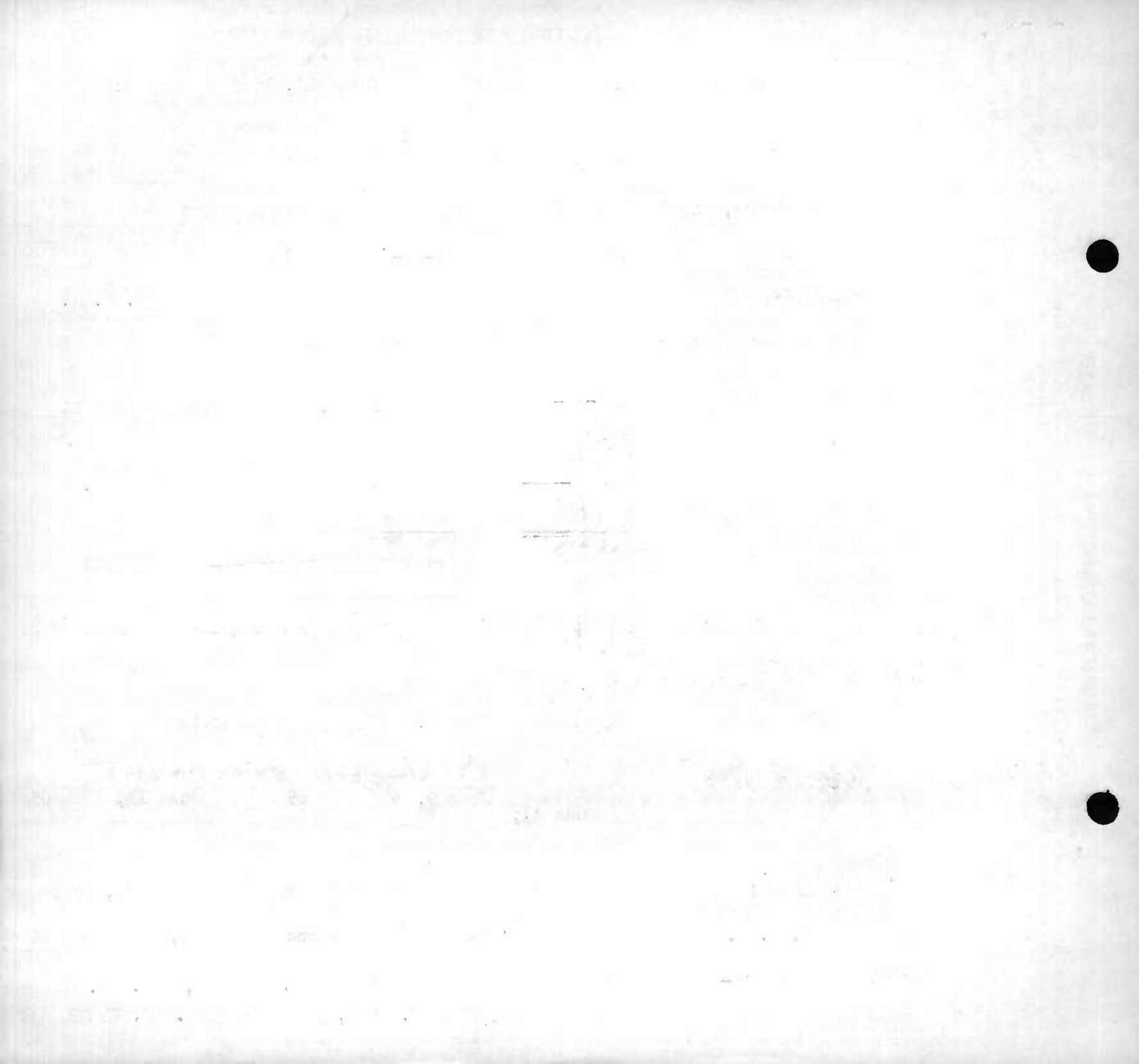
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 6306

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6306	
1. NAME OF DECEASED (Type or Print) Florence Eisenbach			2. DATE AND HOUR OF DEATH June 13, 1965 7:00 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) RURAL Dundalk D. STREET ADDRESS (If rural, give location) 24 Seabright Avenue #21222		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 11-11-88	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Garett Stubblefield		
14. MOTHER'S MAIDEN NAME Matilda Ely			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 213-20-8938			17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #24		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest			INTERVAL BETWEEN ONSET AND DEATH 3 Days		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension Exogenous Obesity Fracture (R) Calcaneus			Years 1 Month		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture, rt calcaneus			1 month		
19A. DATE OF OPERATION May 10, 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Injured foot		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 24 Seabright Ave.	
21D. TIME OF INJURY (APPROX.) May 9 1965		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Slipped over basket	
22. I certify that (I) (this hospital) attended the deceased from June 9, 1965 to June 13, 1965 , that (I) (we) last saw the deceased alive on June 13, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. B. Zachary			M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 13, 1965
23C. PHYSICIAN'S NAME (Type) Dr. J. B. Zachary			23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland #24		
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE June 16-1965		24C. NAME of CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION Eastern Ave. Dundalk, Bal. Co. Md		24E. DATE REC'D BY HEALTH DEPT. JUN 16 1965		24F. NAME OF REGISTRAR Robert E. Farkas	
24G. FUNDRAISING DIRECTOR JOHN J. DUDA		24H. ADDRESS 7922 Wise Ave. Md. 21222		24I. ADDRESS	



1

65 6307

BALTIMORE CITY HEALTH DEPARTMENT

65 6307

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Marie Nichols

2. DATE AND HOUR PRONOUNCED DEAD

June 12, 1965

12:00 Mndt.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

845 S. Bond Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ky

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Warnie Wellman

14. MOTHER'S MAIDEN NAME

Mella Ann Webb

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

Oneida Lohman 404 Wildwood Beach Rd. 21221

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Massive retroperitoneal hemorrhage
DUE TO
blunt force injury to left flank

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Cirrhosis of liver

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

845 S. Bond Street

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

June 11, 1965 6:00A

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

fell striking side on table

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 13, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

June 15/65

23C. NAME of CEMETERY or CREMATORY

Old Williams Mem. Park

23D. LOCATION

(City, town, or county)

(State)

Catlettsburg Ky.

24A. DATE REC'D BY HEALTH DEPT.

JUN 16 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Philip H. Herring, Jr.

ADDRESS

2024 Orleans Sy.

MAIL ROOM

PAID COMMISSION

CERTIFICATE OF DEATH

Registered No. 65 6308

BIRTH NO.

65 6308

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Margaret Wiggs

2. DATE AND HOUR OF DEATH

6-12-65

2:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1302 North Mount Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

5-1-00

9. AGE (In years
last birthday)

65

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Malon

14. MOTHER'S MAIDEN NAME

Mary Jane Stewart

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18.

151X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Sepsis, Focus Unknown
DUE TO

4 Days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) Adenocarcinoma of Stomach
DUE TO

9 Months

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-5-1965 to 6-12-1965,
that (I) (we) last saw the deceased alive on 6-12-1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. Charles Carpenter

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

6-12-65

23C. PHYSICIAN'S
NAME (Type)

Dr. Charles Carpenter

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/16/65

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cmt

24D. LOCATION

Baltimore

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 16 1965

25B. NAME OF REGISTRAR

Robert E. Farley M.D.

25C. FUNERAL DIRECTOR

Choy O. Wilson - 1000 Blandtop Ave

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

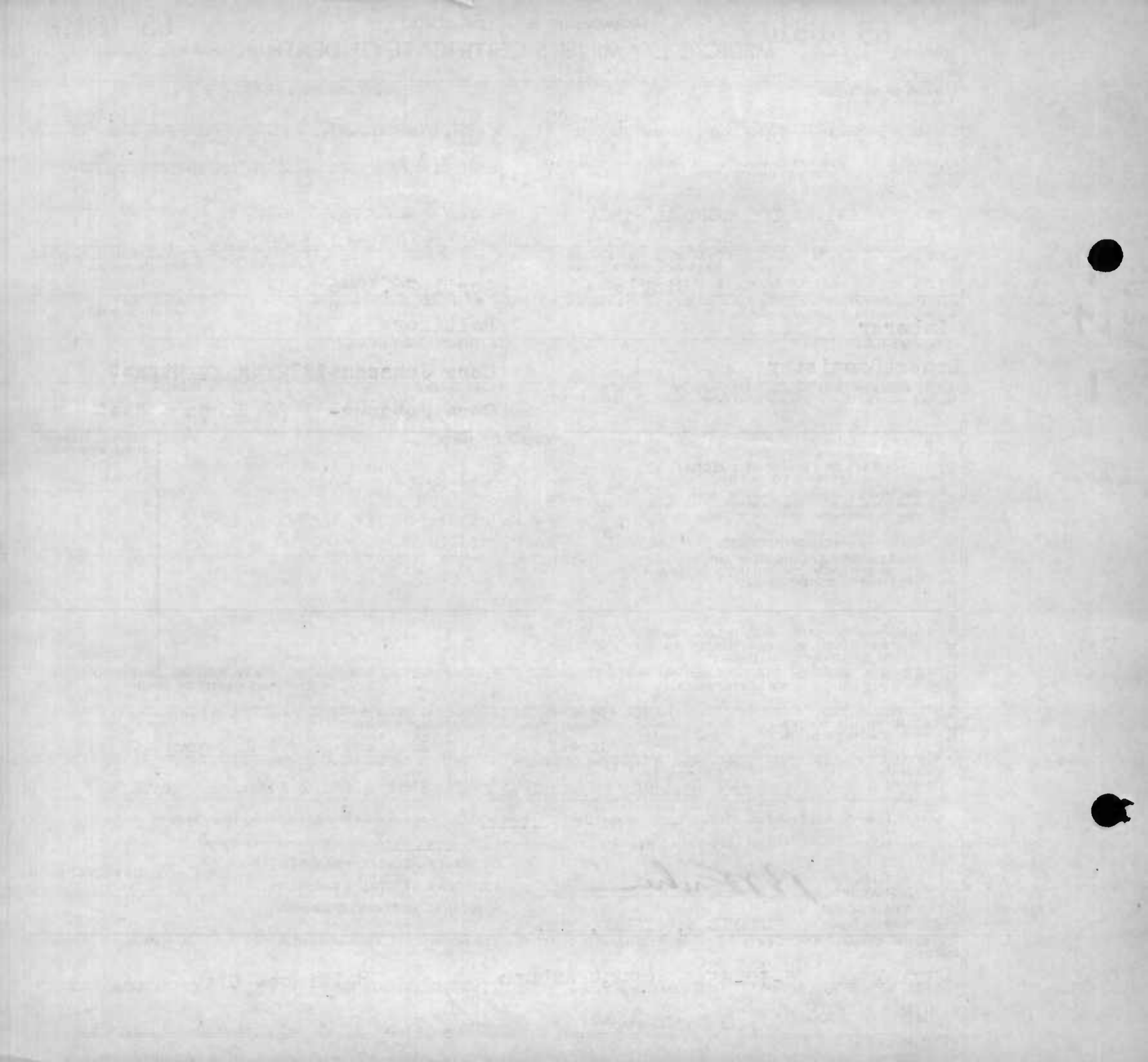
FUNERAL DIRECTOR: IMPORTANT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 6309		65 6309	
CERTIFICATE OF DEATH					
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>Mr. Floyd Watson</i>		
2. DATE AND HOUR OF DEATH <i>June 15, 1965 3 45 P.</i>			M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Home - 1201 W. Franklin St.</i>			A. STATE <i>Maryland</i> B. COUNTY <i>18-02</i>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
			D. STREET ADDRESS (If rural, give location) <i>1201 W. Franklin St.</i>		
5. SEX <i>M</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>Mar. 3, 1923</i>	9. AGE (In years lost birthday) <i>42</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>VA.</i>	
13. FATHER'S NAME <i>Gregory Ward</i>			14. MOTHER'S MAIDEN NAME <i>Irene Jones</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give War or dates of service) <i>Yes WW II</i>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>353.31 Epileptic Seizure</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hour</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Aug 13 1964</i> to <i>June 14 1965</i> , that (I) was last saw the deceased alive on <i>June 7 1965</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death.					
23A. SIGNATURE <i>William H. Watts</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>William H. Watts</i>				23D. ADDRESS <i>515 N. Arlington Ave</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-18-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Balto. Nat. Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 16 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Finkenauer</i>		25C. FUNERAL DIRECTOR ADDRESS <i>C.O. Wilson 1002 Broadway Ave.</i>			

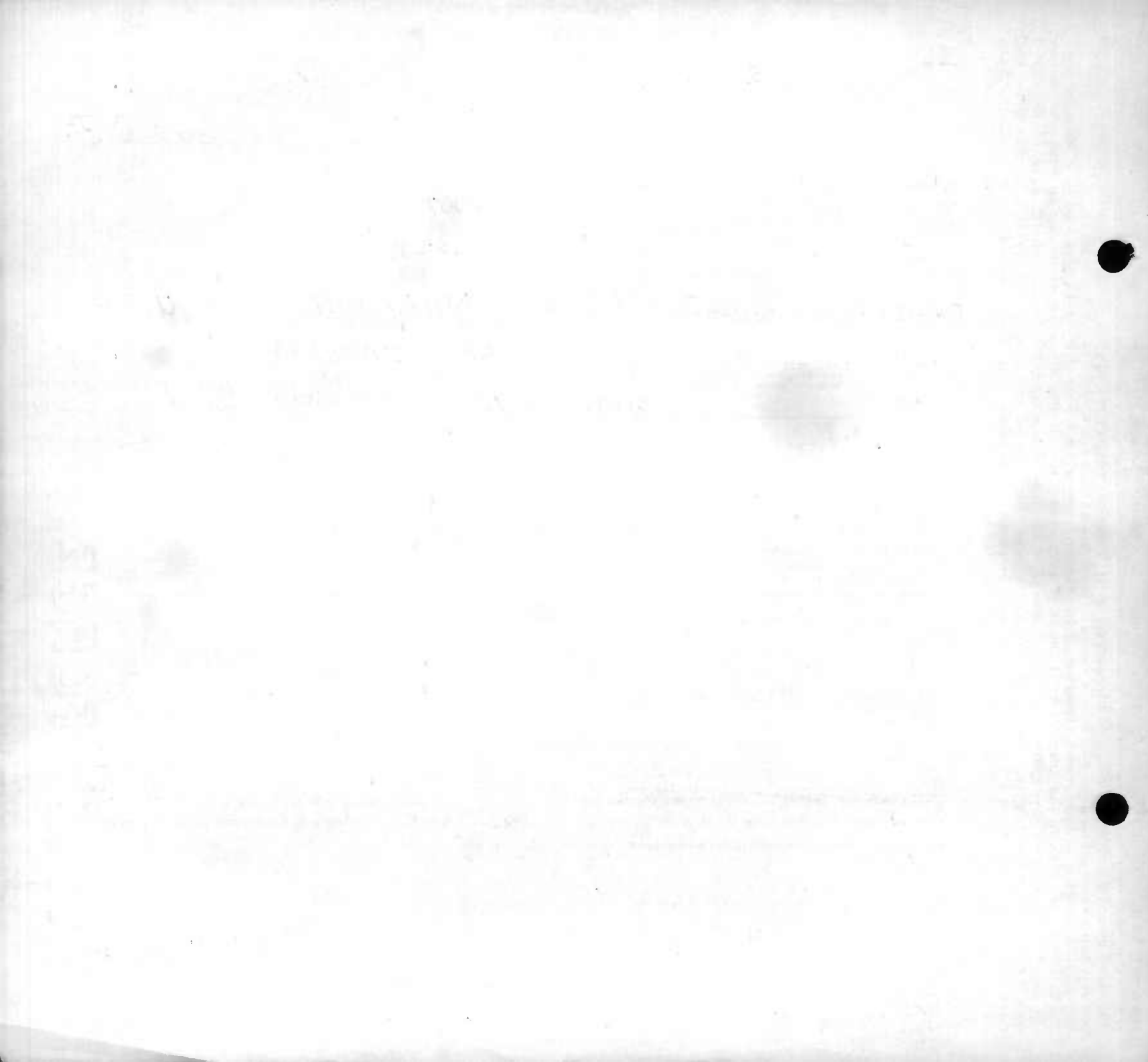
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		65 6310	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
MICHAEL JOHNSON			6-13-65 9:40 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland		
UNIVERSITY HOSPITAL - DOA			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-01		
D. STREET ADDRESS (If rural, give location) 616 W Hamburg Street 21230					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	Colored	Single	April 26, 1946	19	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer				Baltimore	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Ernest Bannister			Cora Johnson I232 X Sharp Street		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Cora Johnson- I232 Sharp Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
E981X1			(A) Multiple bullet wounds		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) DUE TO		
			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Street		In front of 707 S. Fremont Street	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) 6 13 '65 PM		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Shot with 22 Automatic revolver	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
RUSSELL S. FISHER, M.D.			ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
23A. BURIAL CREMATION, REMOVAL (Specify)			23B. DATE		23C. NAME of CEMETERY or CREMATORY
Burial			6-17-65		Mount Auburn
24A. DATE REC'D BY HEALTH DEPT.			24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS
JUN 17 1965			Robert E. Fisher, M.D.		Isaiah L. Brown & Son



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
65 6311					CERTIFICATE OF DEATH					Registered No. 65 6311									
BIRTH NO.					M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) <u>William S. Fialkowski</u>					2. DATE AND HOUR OF DEATH <u>6-12-65</u> <u>3.05 A</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2-03</u>									
FULL NAME OF HOSPITAL OR INSTITUTION: <u>THE JOHNS HOPKINS HOSPITAL</u> (If not in hospital or institution, give street address or location)										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE CITY</u>									
										D. STREET ADDRESS (If rural, give location) <u>2007 EASTERN AVE</u>									
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED <u>WIDOWED</u> <u>DIVORCED</u> (specify)		8. DATE OF BIRTH <u>11-25-03</u>		9. AGE (In years last birthday) <u>61</u>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FUNERAL DIRECTOR + EMBALMER</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>OWN FUNERAL HOME</u>					11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>WILLIAM FIALKOWSKI</u>										14. MOTHER'S MAIDEN NAME <u>MARY ZAMENSKI</u>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO. <u>219-16-9896</u>					17. INFORMANT (WIFE) <u>LAURA FIALKOWSKI</u>					ADDRESS <u>2007 EASTERN AVE. BALTO, MD. 21231</u>				
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u>										CAUSE OF DEATH (A) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(B) DUE TO									
										(C) DUE TO									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION <u>0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>					20A. AUTOPSY? (Yes or No) <u>No</u>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (if) (this hospital) attended the deceased from <u>June 11, 19 65</u> to <u>June 12, 19 65</u> , that (if) (we) last saw the deceased alive on <u>June 12, 19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (if) (We) (did) (not) view the body after death.																			
23A. SIGNATURE <u>Kenneth E. Quickel Jr</u>										M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <u>6-12-65</u>				
23C. PHYSICIAN'S NAME (Type) <u>KENNETH QUICKEL</u>										M.D. <u>JOHNS HOPKINS HOSPITAL</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>					24B. DATE <u>6-15-65</u>					24C. NAME OF CEMETERY or CREMATORY <u>HOLY ROSARY CEMETERY</u>					24D. LOCATION (City, town, or county) (State) <u>BALTO, MD.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 17 1965</u>					25B. NAME OF REGISTRAR <u>Robert E. Farkas</u>					25C. FUNERAL DIRECTOR <u>Wm. Fialkowski</u>					ADDRESS <u>21231 2007 Eastern Ave.</u>				



3-416

65 6312

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 6312

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

James / Gilbert

2. DATE AND HOUR OF DEATH

June 14, 1965

6:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3725 Oakmont Avenue #21215

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Separated

8. DATE OF BIRTH

4-16-98

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

Trucking

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME

John C. Gilbert

14. MOTHER'S MAIDEN NAME

Margaret French

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #21224

18.

053.3 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Klebsiella Sepsis

DUE TO

9 Days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At
Work ☐Not While
At Work ☐22. I certify that (I) (this hospital) attended the deceased from April 4, 19 65 to June 14, 19 65.
that (I) (we) last saw the deceased alive on June 14, 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. B. Zachary

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

June 14, 1965

23C. PHYSICIAN'S
NAME (Type)

Dr. J. B. Zachary

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland #24

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

June 16, 1965

24C. NAME of CEMETERY or CREMATORY

St. Francis Cemetery

24D. LOCATION

Abingdon

(City, town, or county)

Harford Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 17 1965

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

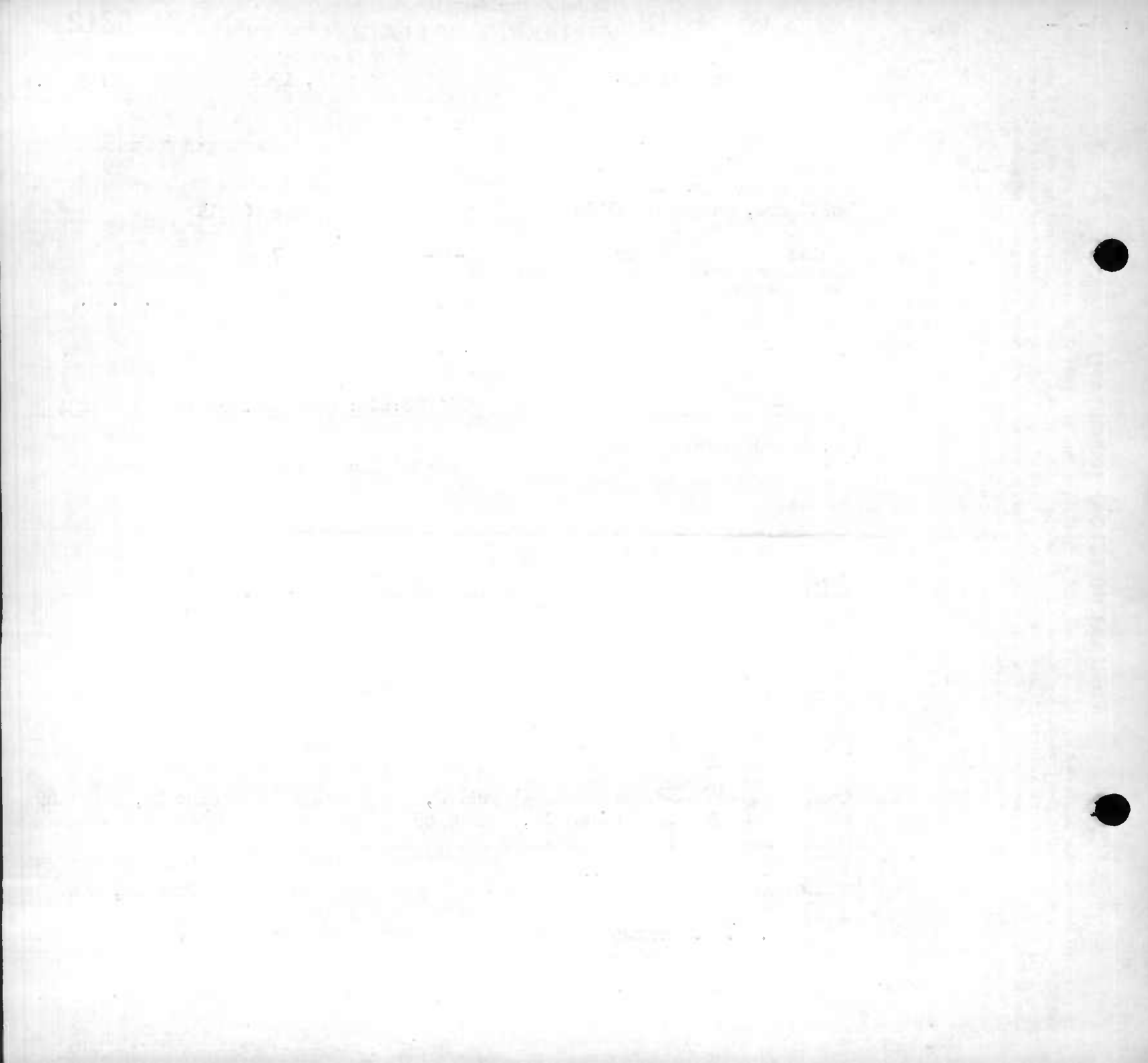
Howard K. McComas, Abingdon Maryland

ADDRESS

Howard K. McComas & Son Abingdon, Md.

FUNERAL DIRECTOR: IMPORTANT

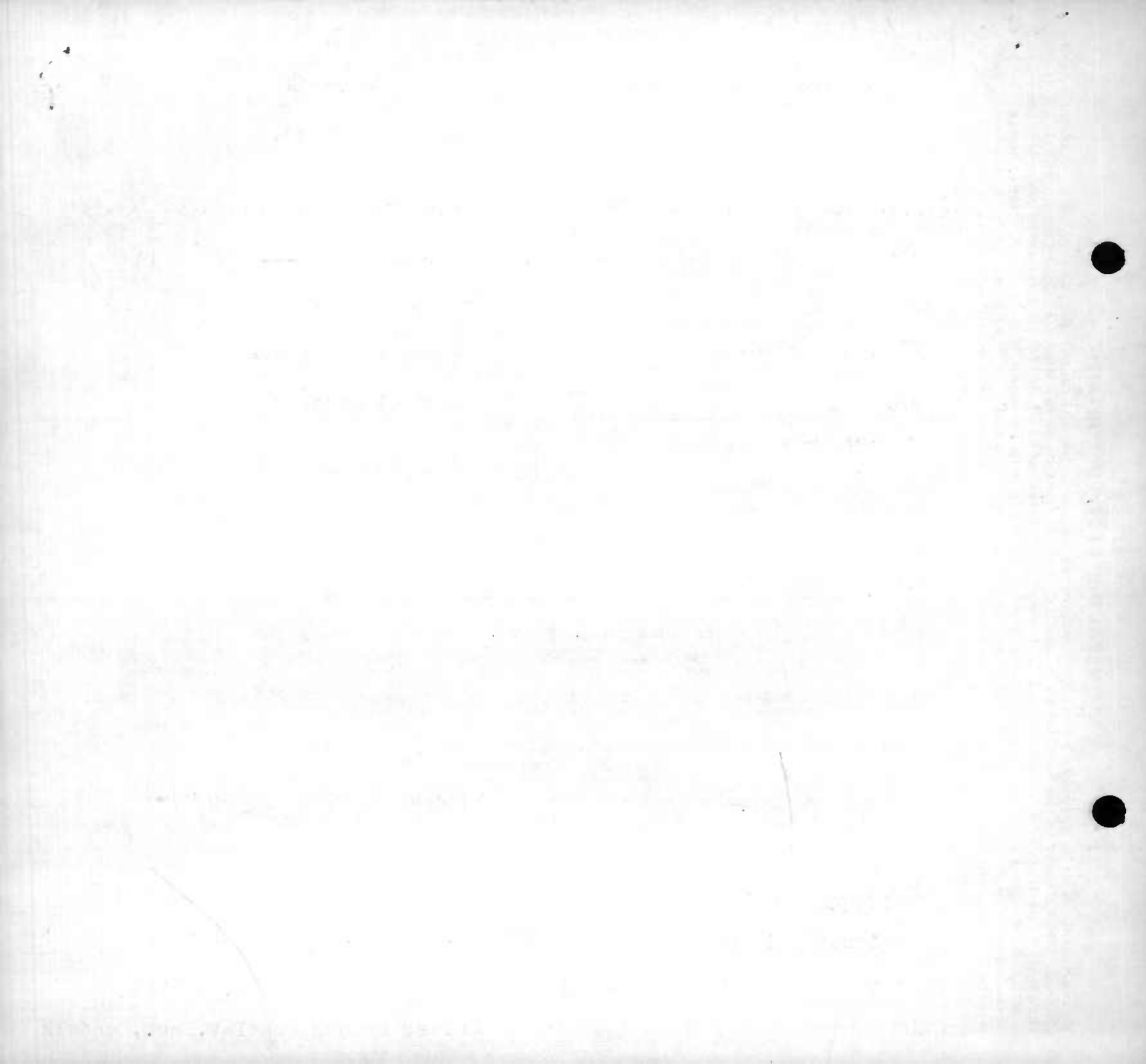
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>6512725</u> <u>65</u> <u>6313</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65</u> <u>6313</u>	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) <u>DUNN, STEVEN</u>			2. DATE AND HOUR OF DEATH <u>6-16-65</u> <u>1:15</u> P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hosp of Balto.</u>			A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto</u> <u>5300</u>		
			D. STREET ADDRESS (If rural, give location) <u>476 Barrison Pt Rd (21)</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>5-27-65</u>	9. AGE (In years last birthday) <u>---</u>	If Under 1 Yr. Months: <u>19</u> Days: <u>19</u> Hours: <u>19</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>New born</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Balto, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Irwin Dunn</u>			14. MOTHER'S MAIDEN NAME <u>Frances Shiebeck</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Hospital Records</u>		
18. <u>603X1</u> CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <u>Renal Shut down</u>			(A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Hypertension; shock</u>			(C) DUE TO		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/13/65</u> 19 to <u>6/16/65</u> 19, that (I) (we) last saw the deceased alive on <u>6/16/65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sidney Seidman</u>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/16/65</u>
23C. PHYSICIAN'S NAME (Type) <u>Sidney Seidman</u>			23D. ADDRESS <u>Sinai Hosp of Balto</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6/17/65</u>	24C. NAME of CEMETERY or CREMATORY <u>Cedar Hill Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 17 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Faldut</u>		25C. FUNERAL DIRECTOR <u>Walter Brooks Bradley, Inc., Dundalk</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 6314		CERTIFICATE OF DEATH		65 6314	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		HARRY Reed Coake		6-15-65 5:10 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Little Sisters of the Poor		md. Dardington Harford Co.			
1200 VALLEY ST.,		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
BALTIMORE md 21202		Dardington md. 62-00			
D. STREET ADDRESS (If rural, give location)		U.S. #1			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
m	w	WIDOWED	FEB. 23, 1874	91	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Farmer				# md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William Coake		Mary Agnes Keithley		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		Little Sas of the Poor 1200 VALLEY ST.	
18. 4-22-1 I S.S. #215-12-1118		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO		Pulmonary embolism	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO		A.S.C.V.D.	
ANTECEDENT CAUSES		(C) DUE TO		Senility - arteriosclerosis	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		19		to 6-15-1965	
that (I) (we) last saw the deceased alive on		6-15-1965		and that in (my) (our) opinion death occurred on the date	
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Stanley Ankudas				6-15-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Stanley Ankudas		M.D. 1802 W. BALTIMORE ST.			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		JUNE 17, 1965		Bel Air Memorial Gardens	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Bel Air, Harford Co., Maryland		JUN 17 1965		Robert E. Farkas	
24G. FUNERAL DIRECTOR		24H. ADDRESS		24I. NAME OF REGISTRAR	
Joseph William Foster		W. Broadway & Williams St.		Bel Air, Maryland 21014	

V.S. 153 6-22-65 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. M.E. CASE NO.		65 6315		65 6315	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Fred J. Nelson			6-11-65 9 AM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Mercy Hospital			Maryland Baltimore		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Catonsville		
			D. STREET ADDRESS (If rural, give location)		
			5914 Charnwood Road		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.
Male	White	Married	May 3, 1925	40	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Accountant		Telephone		Winthrop, Massachusetts	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Lyman B. Nelson			Kathryn B. Bauer		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		WW11 098-1805255		104 Warwick Ave Mr. Robt. Nelson Lutherville, Maryland	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO		
			Bleeding from stress ulcer 2 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
			acute fulminating ulcerative colitis with perforation.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) DUE TO		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
8-30-65		Bowel perforation		yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				YES	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 18 May 1965 to 11 June 1965, that (I) (we) last saw the deceased alive on 11 June 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Manuel D. Ramos			6-11-65		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
MANUEL D. RAMOS			MERCY HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		6-15-1965		Baltimore, National Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 17 1965 Robert E. Jackson				Wm. Cook-Brooks Towson 1050 York Road 21204 Towson, Maryland	

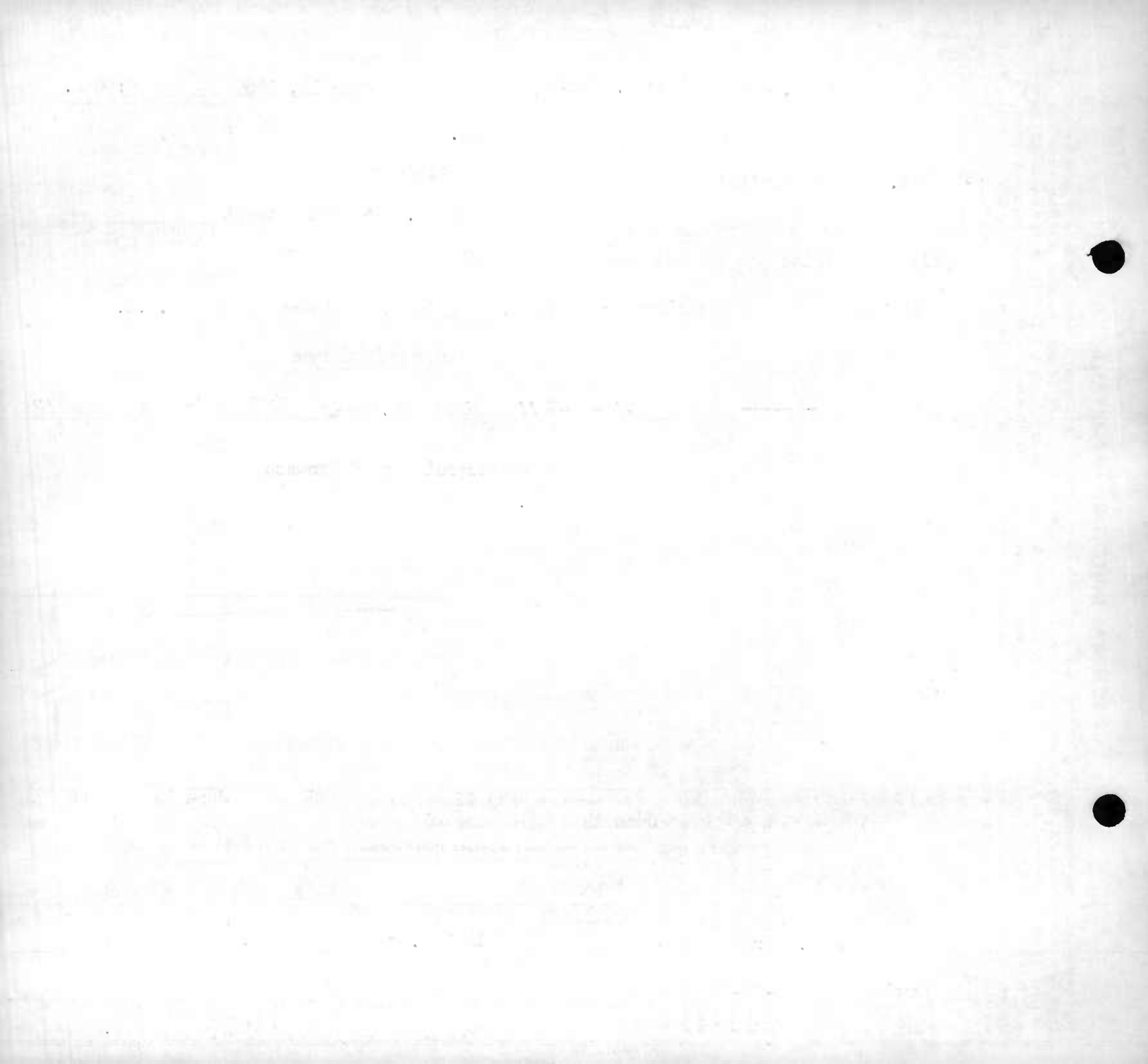


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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

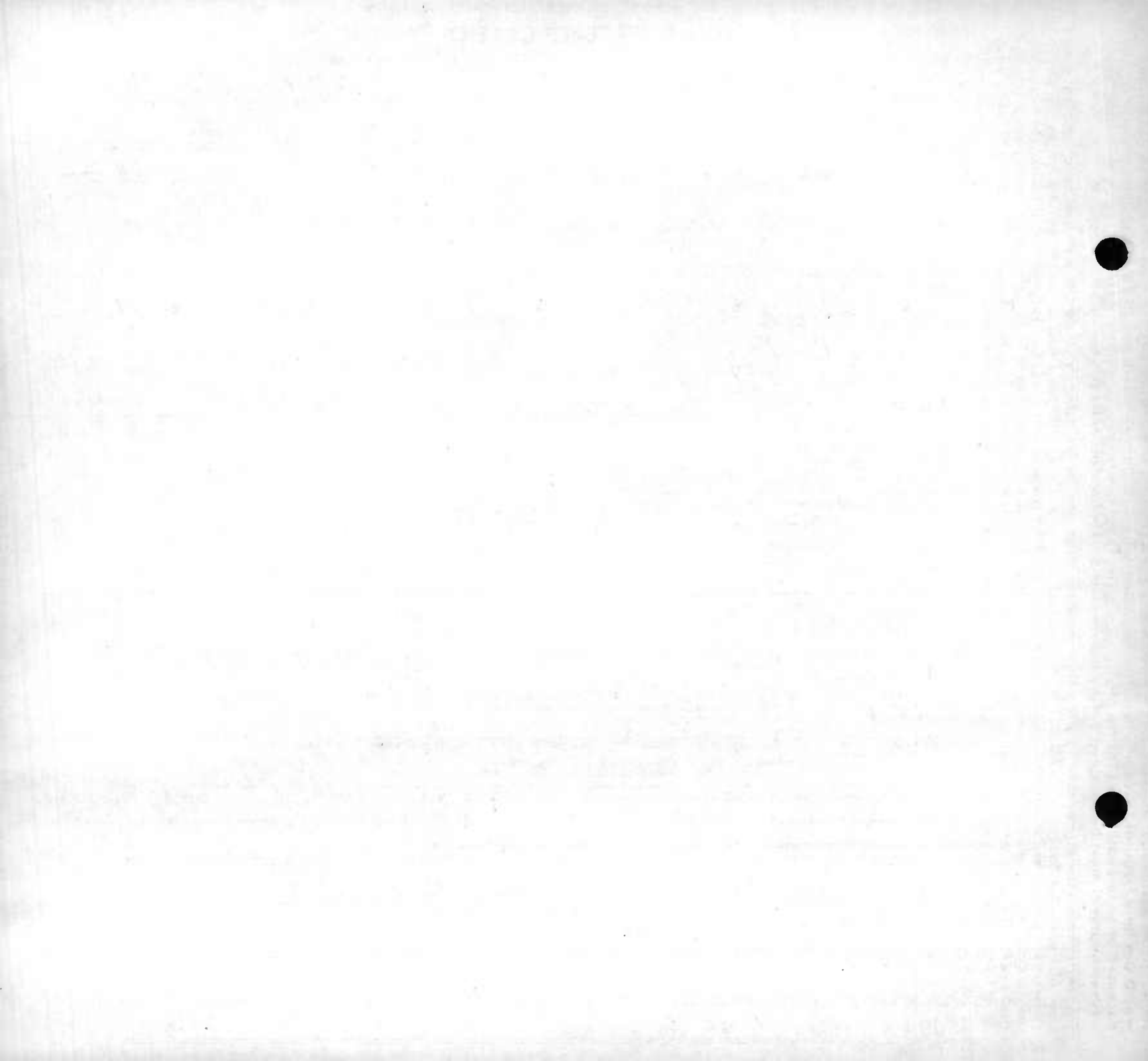
BIRTH NO. 65 6316				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6316	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BAETZ, JOHN (John B. Baetz)				2. DATE AND HOUR OF DEATH June 14, 1965 9:50 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY F01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 24 D. STREET ADDRESS (If rural, give location) 728 S. Robinson Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 7/18/86	9. AGE (In years lost birthday) 78	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY American Can Company		11. BIRTHPLACE (State or foreign country) Maryland, Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Baetz				14. MOTHER'S MAIDEN NAME Margaret Stocker			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-09-5011		17. INFORMANT William G. Baetz ADDRESS 5407 Spring Lake Lane #12			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma of Stomach ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 22 1965 to June 14 1965 , that (I) (we) last saw the deceased alive on June 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Juan G. Gan M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/14/65	
23C. PHYSICIAN'S NAME (Type) Juan G. Gan M.D.				23D. ADDRESS 1400 N. Caroline Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-18-65		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery		24D. LOCATION (City, town, or county) (State) 7401 German Hill Road Balto. 22, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 17 1965		25B. NAME OF REGISTRAR Robert E. Jankowski		25C. FUNERAL DIRECTOR ADDRESS Charles J. Jankowski 9015 CONKLING ST. BALTO. 21224, MD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

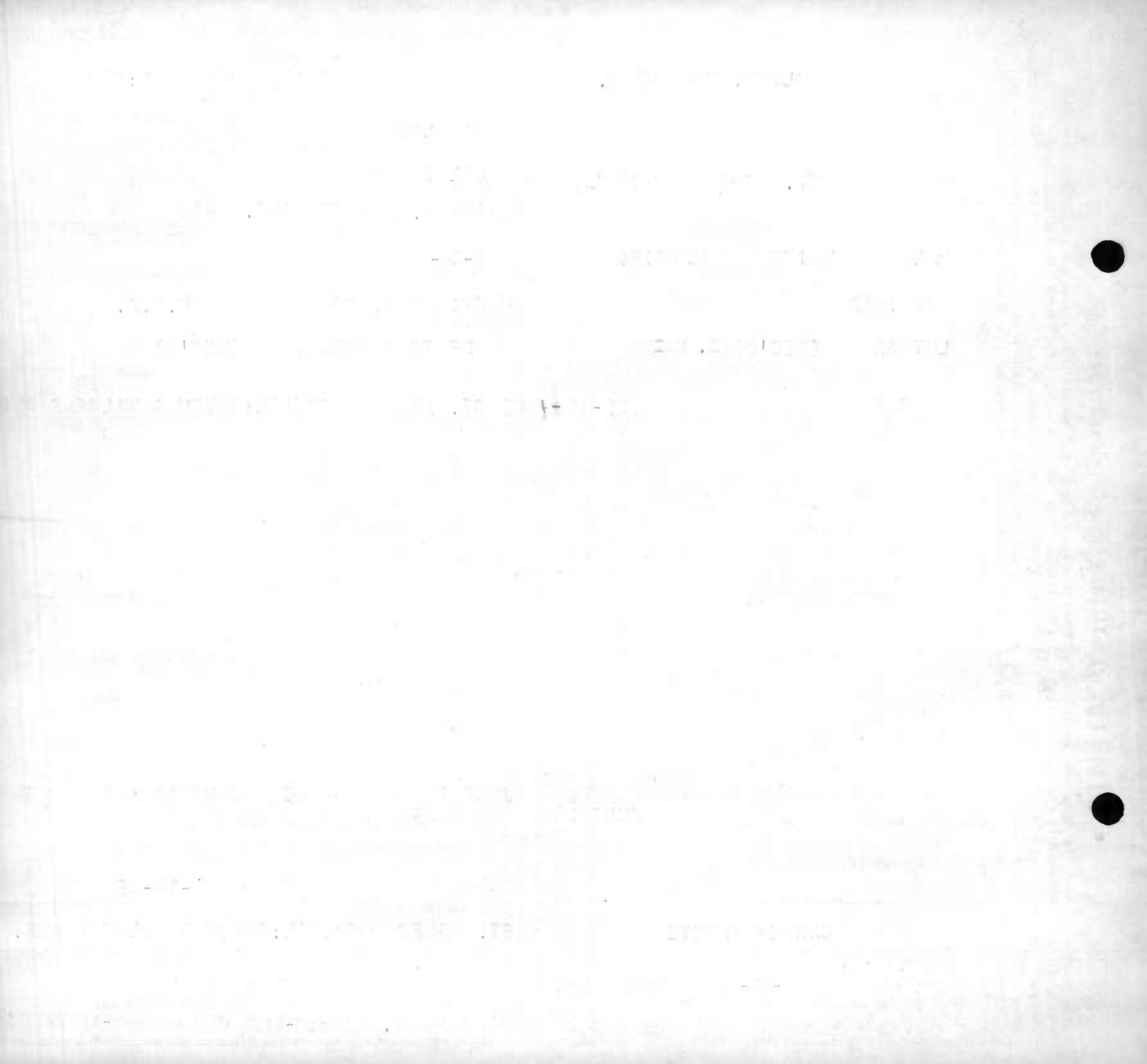
BIRTH NO. 65 6317				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6317	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BELING GEORGE				2. DATE AND HOUR OF DEATH 12 50 AM 6/13/65			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 517 SDECKER AVE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 4/23-97	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10B. KIND OF BUSINESS OR INDUSTRY Mill work		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Beling				14. MOTHER'S MAIDEN NAME Elizabeth Stacharowski			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 215-09-4894		17. INFORMANT 'WIFE' 1 Daughter			
18. 467.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) BLEEDING ULCER (OPERATED) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. SEPSIS				INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION 6-6-65				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BLEEDING ULCER		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-5-65 to 6-13-65 , that (I) (we) last saw the deceased alive on 6-12-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph J. Matthews				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/13	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-16-65		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 17 1965		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Nicholas T. Matthews		ADDRESS 3221 Eastern Ave, Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

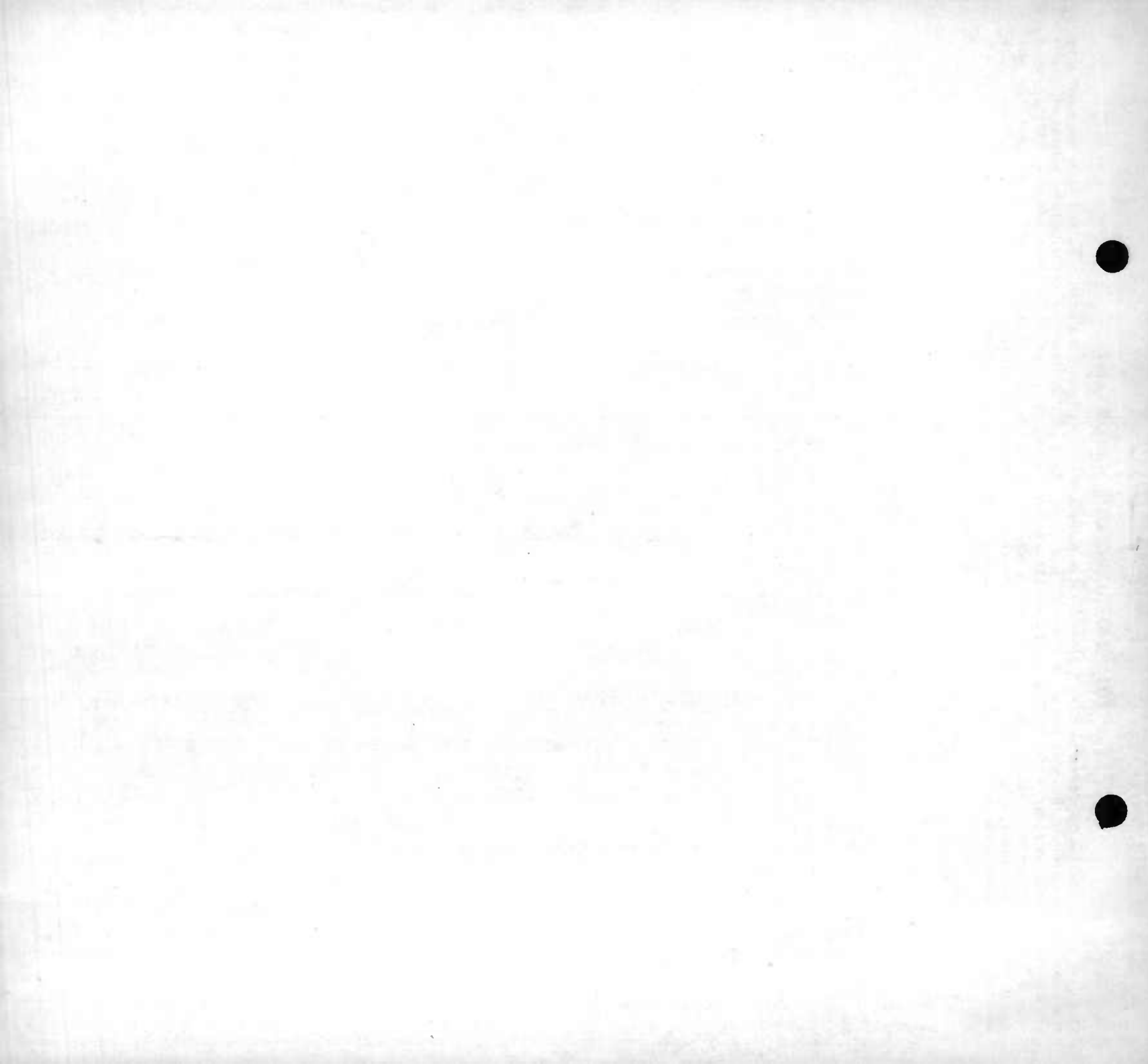
BIRTH NO. 65 6318		CERTIFICATE OF DEATH		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6318	
M.F. CASE NO.		1. NAME OF DECEASED (Type or Print) KLINE, GEORGE F.				2. DATE AND HOUR OF DEATH JUNE 14, 1965 3:15P	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 20-08 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 440 S. AUGUSTA AVE. #29			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-16-84	9. AGE (In years last birthday) 81	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) HUNTINGTON, PENNA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LUTHER (DEC'D) B. KLINE				14. MOTHER'S MAIDEN NAME REBECCA MILLER (DEC'D)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 705-10-1805		17. INFORMANT ADDRESS #29 ST. AGNES HOSPITAL; CATON & WILKENS AVE			
18. 451X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Coritic aneurysm, abd DUE TO (B) arteriosclerosis DUE TO (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JUNE 10 19 65 to JUNE 14 19 65 , that (I) (we) last saw the deceased alive on JUNE 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Carmen Fratto				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-14-65	
23C. PHYSICIAN'S NAME (Type) CARMEN FRATTO				23D. ADDRESS M.D. ST. AGNES HOSPITAL; CATON & WILKENS AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-17-65		24C. NAME of CEMETERY or CREMATORY Lorraine Park		24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 17 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard-4107 Wilkens Ave-21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

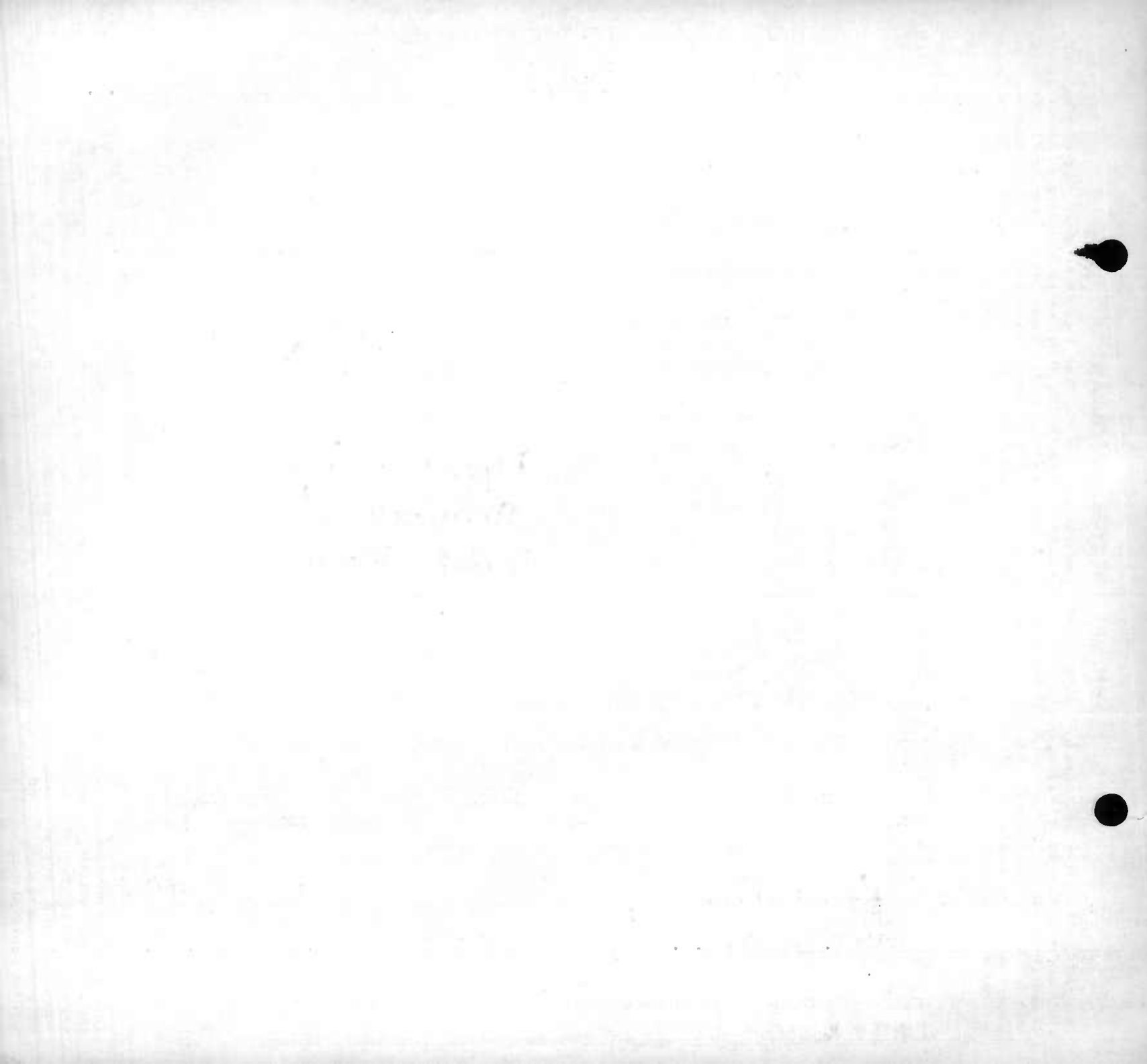
BIRTH NO. 65 6319				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6319	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>nee CLARKE</i> ELIZABETH Bond				2. DATE AND HOUR OF DEATH <i>6/16/65</i> <i>12 M</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <i>MD</i>		B. COUNTY <i>6-05</i>	
<i>SINAI HOSPITAL, BALTIMORE</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>			
5. SEX <i>F</i>				6. RACE <i>C</i>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>divorced</i>				8. DATE OF BIRTH <i>7/10/04</i>			
9. AGE (In years lost birthday) <i>60</i>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>			
11. BIRTHPLACE (State or foreign country) <i>BALTIMORE</i>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Matthew Clarke</i>				14. MOTHER'S MAIDEN NAME <i>Annie Woodland</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>SISTER: GLADYS RANDALL - SAME</i>	
18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) <i>RESPIRATORY + CARDIAC</i>			
ANTECEDENT CAUSES				(B) <i>EVA</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<i>HAS CVD</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<i>0</i>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <i>6/14/1965</i> to <i>6/16/1965</i> , that (I) (we) lost saw the deceased alive on <i>6/16/1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Peter A. Papayannou</i>				M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/16/65</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <i>Sinai Hospital, Balto.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/19/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 17 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>1011-13 Sullivan Funeral Home - N. Arlington Ave</i>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6320				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6320	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Margaret Davis				2. DATE AND HOUR OF DEATH 6-10-65 7 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 D.B. B.W.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 2302			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 11 E. RANDALL ST			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED M.	8. DATE OF BIRTH 10-5-04	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thos. J. Steinhilber				14. MOTHER'S MAIDEN NAME Adg Wible			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family Same		ADDRESS	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO myocardial infarction (B) DUE TO arteriosclerosis (C) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5/15/65 to 6/10/65 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 6/10/65 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Earlie H. Francis				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/10/65	
23C. PHYSICIAN'S NAME (Type) Earlie H. Francis, M.D.				23D. ADDRESS 1213 Light Street, Baltimore, Md. 21230			
24A. BURIAL, CREMATION, REMOVAL (Specify) B		24B. DATE 6-15-65		24C. NAME OF CEMETERY or CREMATORY Holy Cross		24D. LOCATION (City, town, or county) (State) Balto.	
25A. DATE REC'D BY HEALTH DEPT. JUN 17 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR W. C. Coffey		ADDRESS	



BIRTH NO.

65 6321

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 6321

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)J.
FRANK BEDNAR

2. DATE AND HOUR PRONOUNCED DEAD

June 15, 1965

5:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

823 N. Madeira Street (823)

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

Jan. 17, 1924

9. AGE (in years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank C. Bednar

14. MOTHER'S MAIDEN NAME

Adeline Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

217-22-974

17. INFORMANT

ADDRESS

Leroy J. Steffe-823 N. Madeira St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular

(A)
DUE TO

disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-16-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-19-65

23C. NAME of CEMETERY or CREMATORY

Oaklawn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

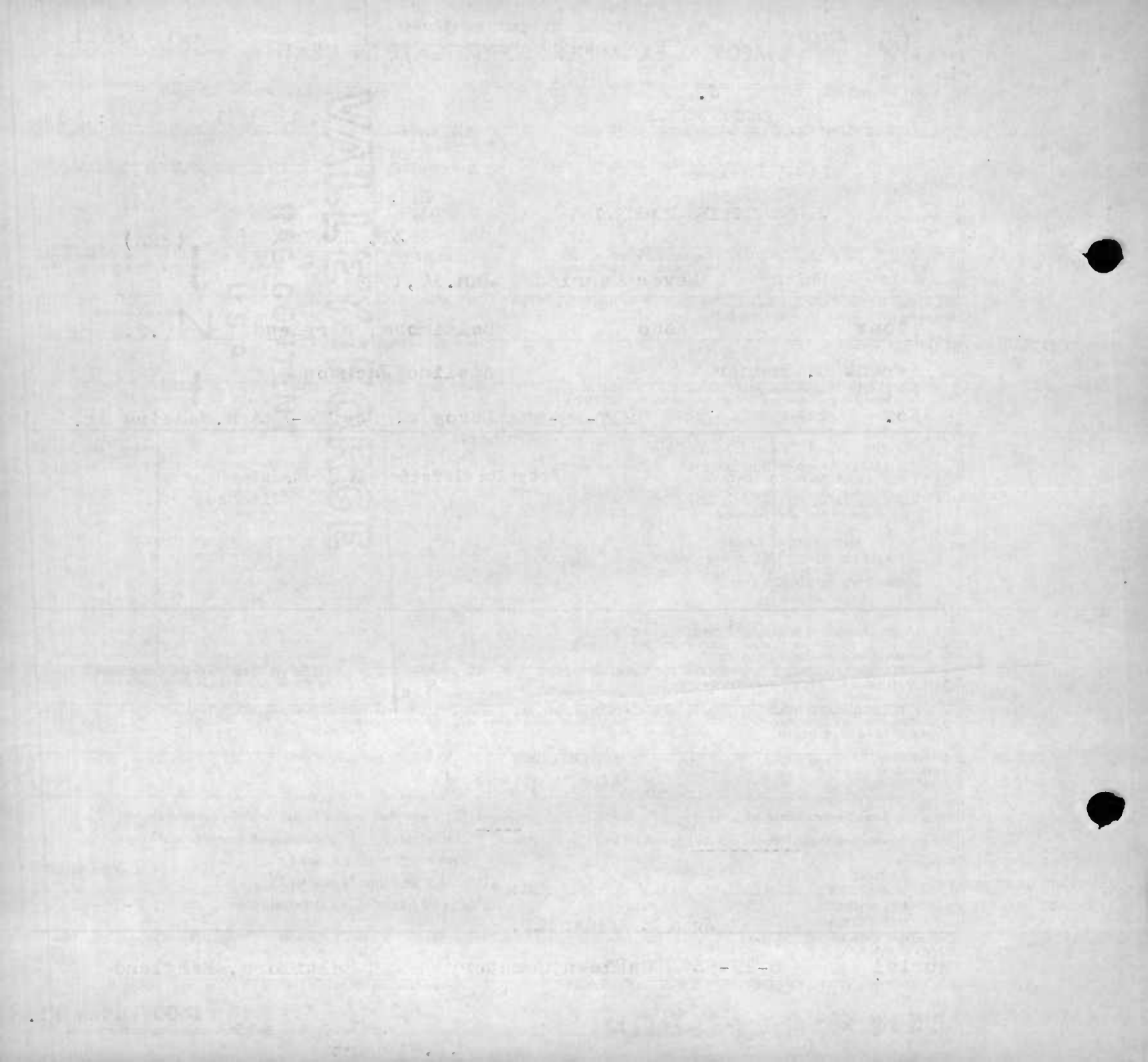
ADDRESS

JUN 17 1965

Robert E. Johnson

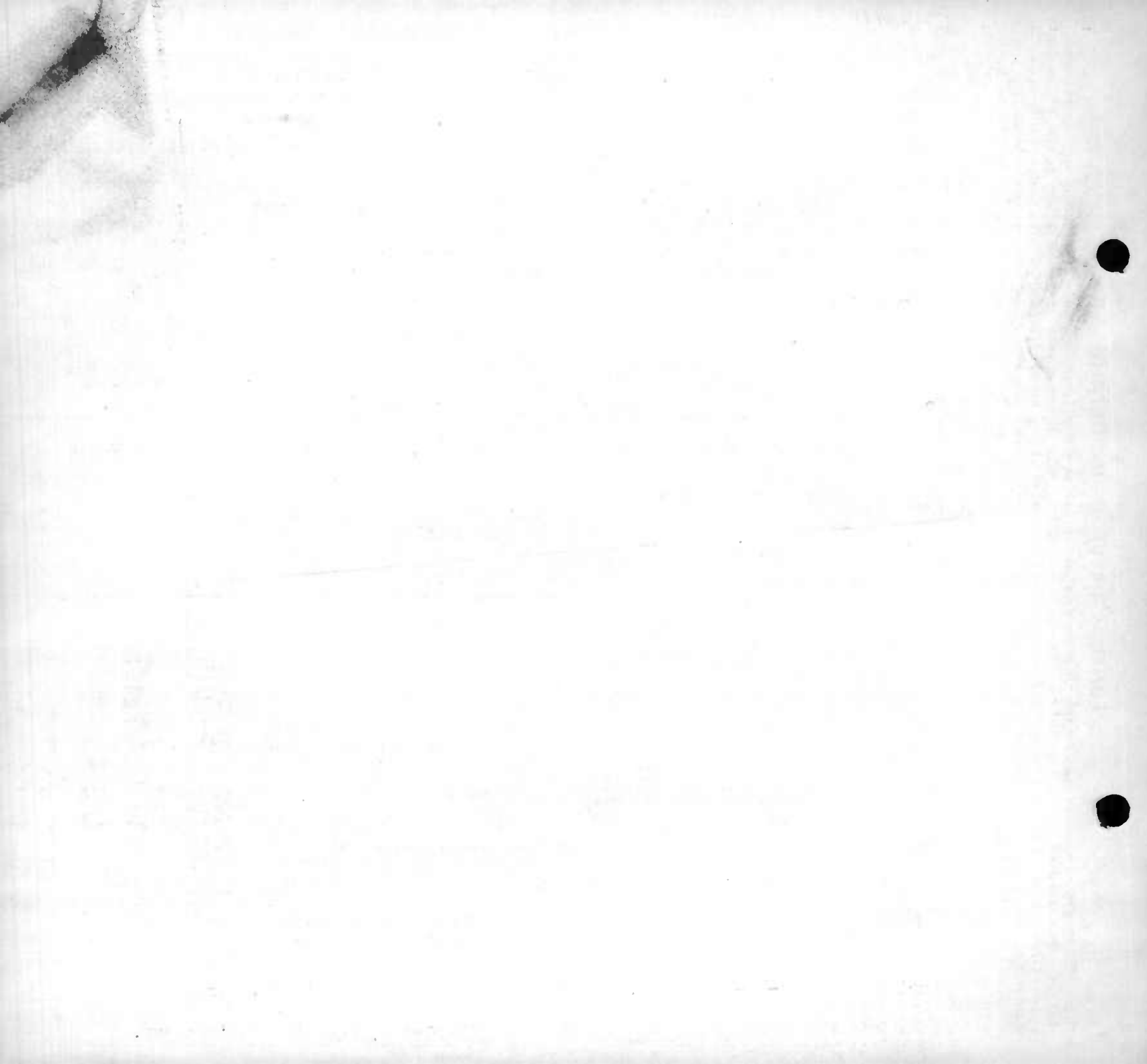
F.B. Wippert

1300 Eutaw Pl.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Certificate of Death		Registered No. 65 6322	
BIRTH NO. 65 6322		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Beasley, Marion C.		2. DATE AND HOUR OF DEATH June 16, 1965 7:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore 24, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY			
5. SEX Female		6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 7-9-75	
9. AGE (In years last birthday) 89		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME George T. Bowen				14. MOTHER'S MAIDEN NAME Martha Ann Thomas			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-14-2904		17. INFORMANT RECORDS BCH		ADDRESS 4940 Eastern Avenue Baltimore 24, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Uremia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Chronic Renal Disease of Unknown Etiology				INTERVAL BETWEEN ONSET AND DEATH 8 weeks			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 2, 1965 to June 16, 1965, that (I) (we) last saw the deceased alive on June 16, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE H. Rath				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 16, 1965	
23C. PHYSICIAN'S NAME (Type) Howard Rathbun				23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore 24, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-19-65		24C. NAME of CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 17 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Charles R. Law 802 Madison Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

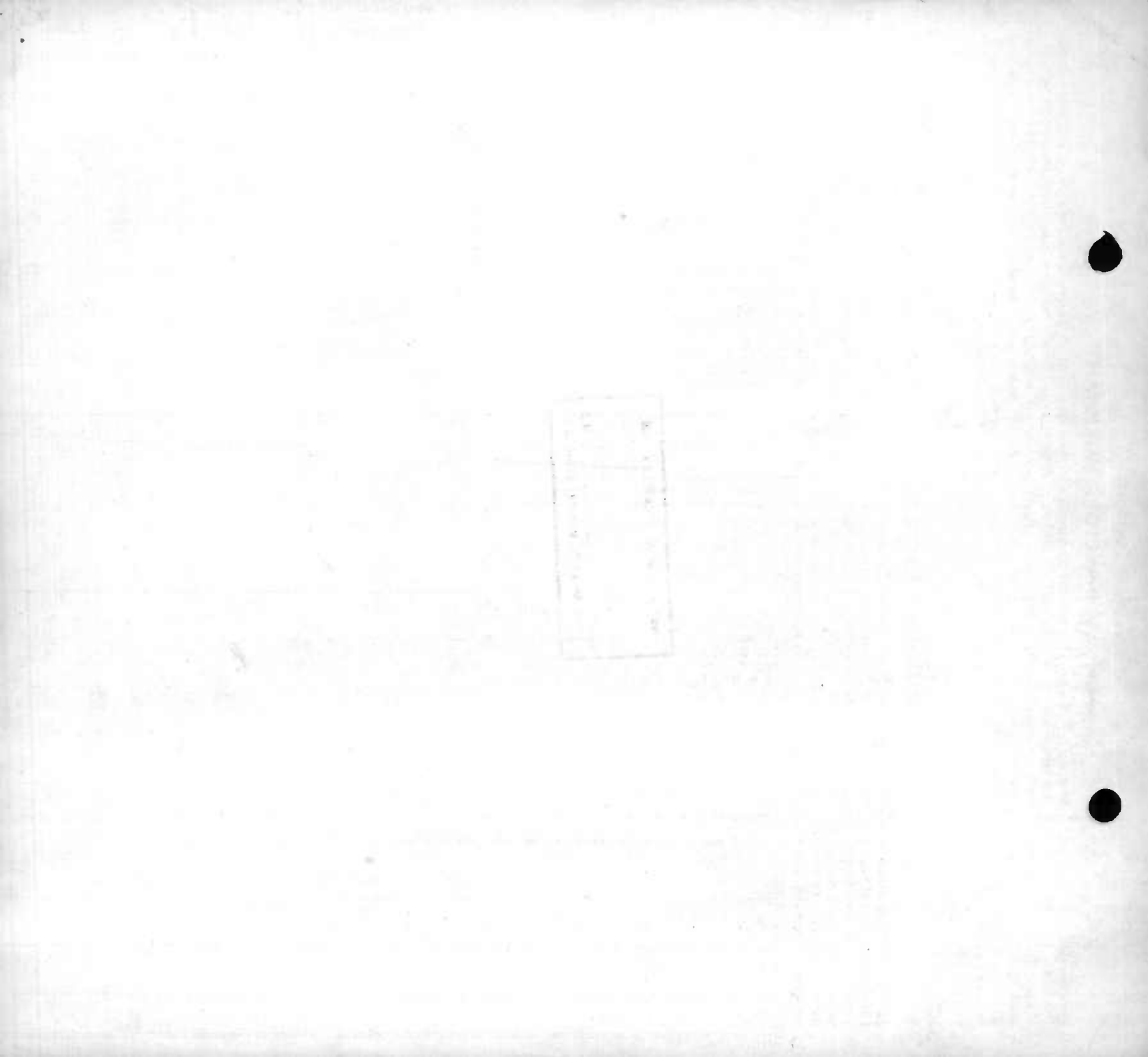
BIRTH NO. F520		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6323	
M.E. CASE NO. 65 6323		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GORDON FINNESSY		2. DATE AND HOUR OF DEATH 6-14-65 4:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQ. HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 1317 HEATHER HILL RD BALTO. D. STREET ADDRESS (If rural, give location) 1317 HEATHER HILL RD 5300			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 4-2-19	9. AGE (In years last birthday) 46	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EDWARD FINNESSY		14. MOTHER'S MAIDEN NAME MARY OWENS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Doris V. Finnessy	
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, give rise to the above cause (A) stating UNDERLYING CONDITION last. MYOCARDIAL INFARCTION 2 hrs.		19. CAUSE OF DEATH MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		NOT A MEDICAL EXAMINER'S CASE N.D. CHIEF MEDICAL EXAMINER Charles J. [Signature] 6/24/65			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) STREET		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) STREET	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? HEART ATTACK	
22. I certify that (I) (this hospital) attended the deceased from 6-14-65 to 6-14-65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Romeo A. Ferrer		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ROMEO A. FERRER		23D. ADDRESS FRANKLIN SQ HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/18/65		24C. NAME OF CEMETERY or CREMATORY PARKWOOD CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTO.		25A. DATE REC'D BY HEALTH DEPT. JUN 17 1965			
25B. NAME OF REGISTRAR R. E. Farley, M.D.		25C. FUNERAL DIRECTOR WIEDEFELD & SON-501 E. 22nd ST			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
65 63245-1555											
BIRTH NO. 65 63245-1555											
CERTIFICATE OF DEATH											
Registered No. 65 63245-1555											
1. NAME OF DECEASED (Type or Print) <i>Robert G. Wackes</i>						2. DATE AND HOUR OF DEATH <i>5-29-65</i> <i>12 15 P. M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>D.O.A.</i> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland Gen. Hospital.</i>						4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>30 E. Lanvale.</i>					
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i>		8. DATE OF BIRTH <i>2/6/03</i>	9. AGE (In years last birthday) <i>62</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Beth. Steel Ship Bldg.</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Robert Wackes</i>						14. MOTHER'S MAIDEN NAME <i>Minnie - ?</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
18. <i>420.14-1527</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute Myocardial Infarction</i> INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>											
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, give rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>ASVD.</i>											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Cholecystitis & Cholelithiasis</i> <i>Carcinoma Terminal Ileum</i>											
19A. DATE OF OPERATION <i>Apr. 22.</i>		19B. CONDITION WHEN OPERATION WAS PERFORMED <i>Cholecyst. - Perforated Cecum & Ileum</i>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Lawrence M. Jerra</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>						23B. DATE SIGNED <i>5-29-65</i>					
23C. PHYSICIAN'S NAME (Type) <i>LAWRENCE M. JERRA</i>						23D. ADDRESS <i>11 E. Chase St</i>					
24A. BURIAL CREMATION REMOVAL (Specify) <i>JUN 3 1965</i>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <i>JOHNS HOPKINS MEDICAL SCHOOL</i>		24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 17 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>		25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCHD</i>		ADDRESS					



65 6325

BALTIMORE CITY HEALTH DEPARTMENT

65 6325

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EMMA HARPER

2. DATE AND HOUR PRONOUNCED DEAD

June 16, 1965

1:00 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4606 Manordene Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

9-15-1896

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during last of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Charleston - W. Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Silas Jefferson Yost

14. MOTHER'S MAIDEN NAME

MURRILL

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

ANNA JACQUES - 1904 HILLCREST RD #7

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular

(A) DUE TO

disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-16-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-19-65

23C. NAME of CEMETERY or CREMATORY

Glendale Cemetery

23D. LOCATION

(City, town, or county)

(State)

South Charleston, West, W. Va

24A. DATE REC'D BY HEALTH DEPT.

JUN 17 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Ellsworth Armacost 4600 Liberty
Ellsworth Armacost - Hgts Ave -

WALKLEY (PO BOX)

WALKLEY (PO BOX)

WALKLEY (PO BOX)

Y

WALKLEY (PO BOX)

WALKLEY (PO BOX)

BIRTH NO. 65 6326 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
PATRICIA ann HARRY		6-13-65 12:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4004 Park Heights Avenue 21215	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH March 17, 1961
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 4
13. FATHER'S NAME Wm. Thomas Harry		11. BIRTHPLACE (State or foreign country) Baltimore Co.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. None		14. MOTHER'S MAIDEN NAME June Leatherwood	
17. INFORMANT June Sowder - 4004 Park Heights Avenue		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH (A) DUE TO Cerebral and spinal injury luxation and fracture of cervical spine (B) DUE TO (C)	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		20A. AUTOPSY? (Yes or No) Yes	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 59' North of Shirley Avenue		21D. TIME OF INJURY (APPROX.) 6 7 '65 PM	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pedestrian - Struck by auto	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6/16/65	
23C. NAME OF CEMETERY or CREMATORY Mt. Olive Cemetery		23D. LOCATION (City, town, or county) (State) Randallstown, Maryland	
24A. DATE REC'D BY HEALTH DEPT. JUN 17 1965		24B. NAME OF REGISTRAR Robert E. Farber, M.D.	
24C. FUNERAL DIRECTOR Ellsworth Armacost		24D. ADDRESS 4600 Liberty Hgts. A.	

WALLEY FORGE

HAS CONTINUED

1000

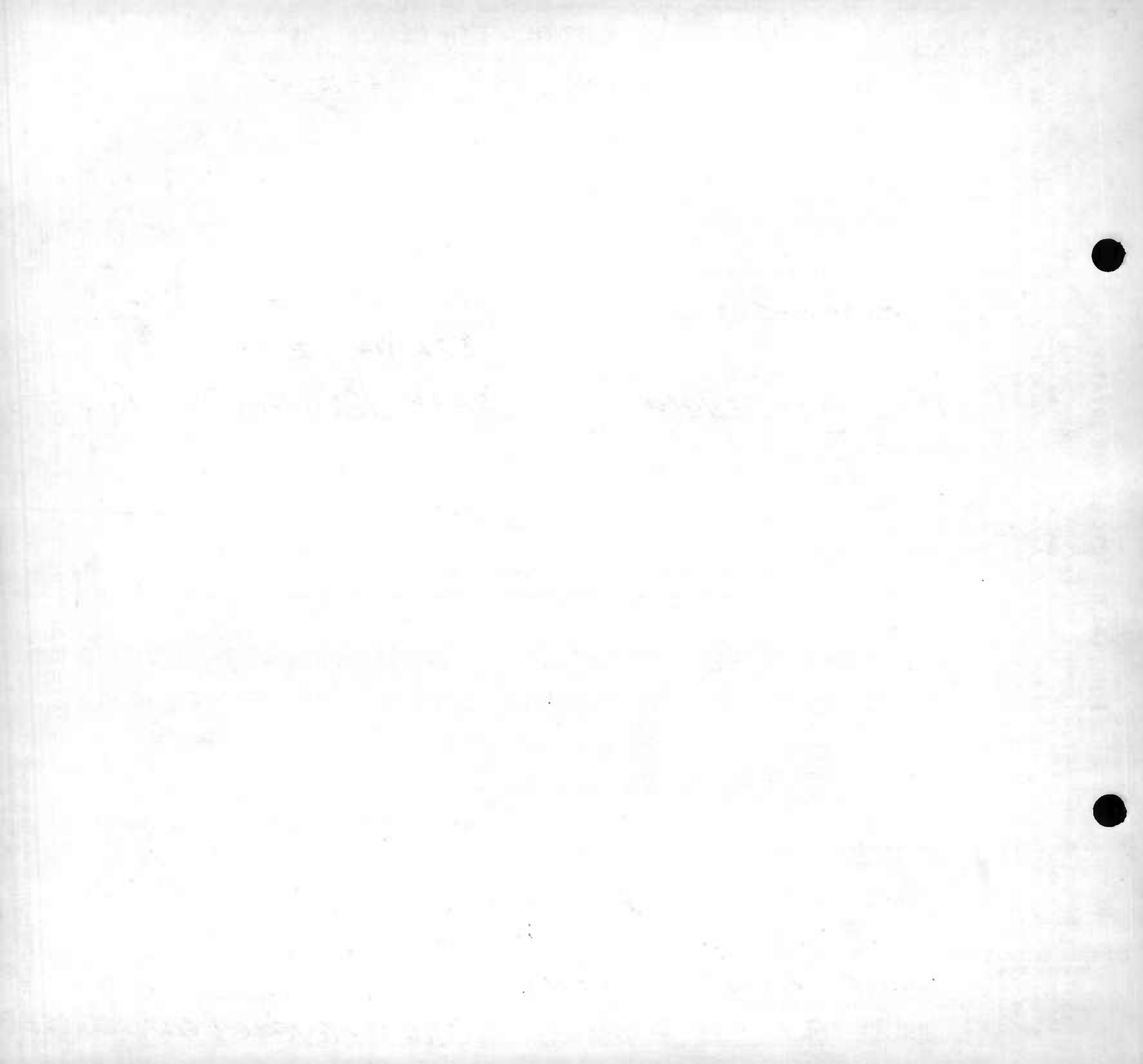
U. W. 1000 - 1000 - 1000 - 1000

1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

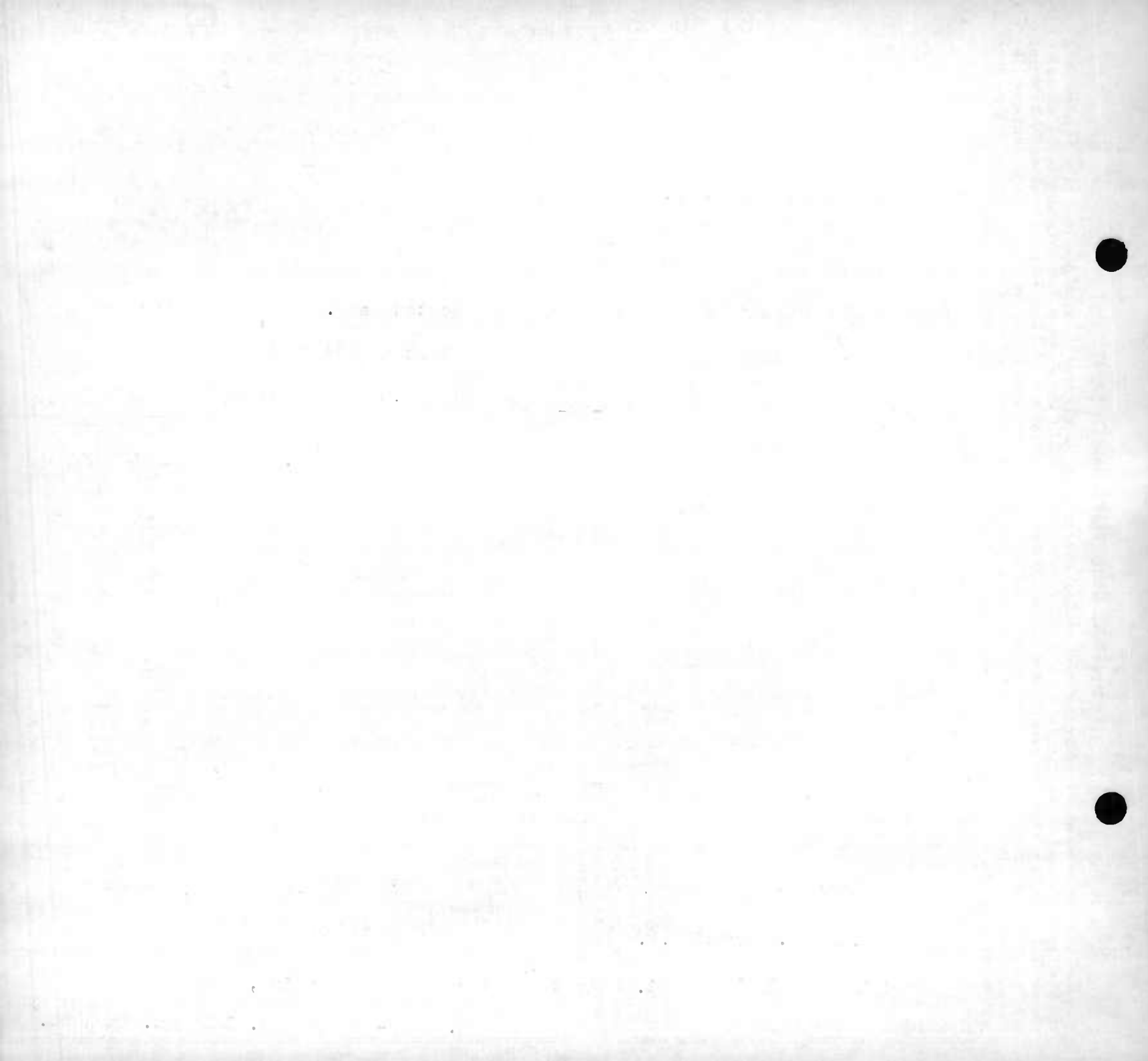
BALTIMORE CITY HEALTH DEPARTMENT									
65 6327					BIRTH NO.				
65 6327					CERTIFICATE OF DEATH				
Registered No. 65 6327					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) SPENCER L. BRUNSON, SR					2. DATE AND HOUR OF DEATH 6-15-65 2:35 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 841 S. PACE ST.				
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH JAN. 23, 1920	9. AGE (In years last birthday) 45	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME OLIVIA BAILEY				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 2/12/42 TO 6/12/45			16. SOCIAL SECURITY NO.		17. INFORMANT SARA BRUNSON				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.11					CAUSE OF DEATH (A) PROB. ACUTE MYOCARDIAL INFARCT DUE TO (B) ARTERIOSCLEROTIC C. V. D. DUE TO (C)				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 15 JUNE 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Bruce A. Mallin					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 15 JUNE		
23C. PHYSICIAN'S NAME (Type) BRUCE A. MALLIN					23D. ADDRESS UNIVERSITY HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/21/65		24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town or county) (State) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 17 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Charles Arthur		ADDRESS 6610 Bare St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

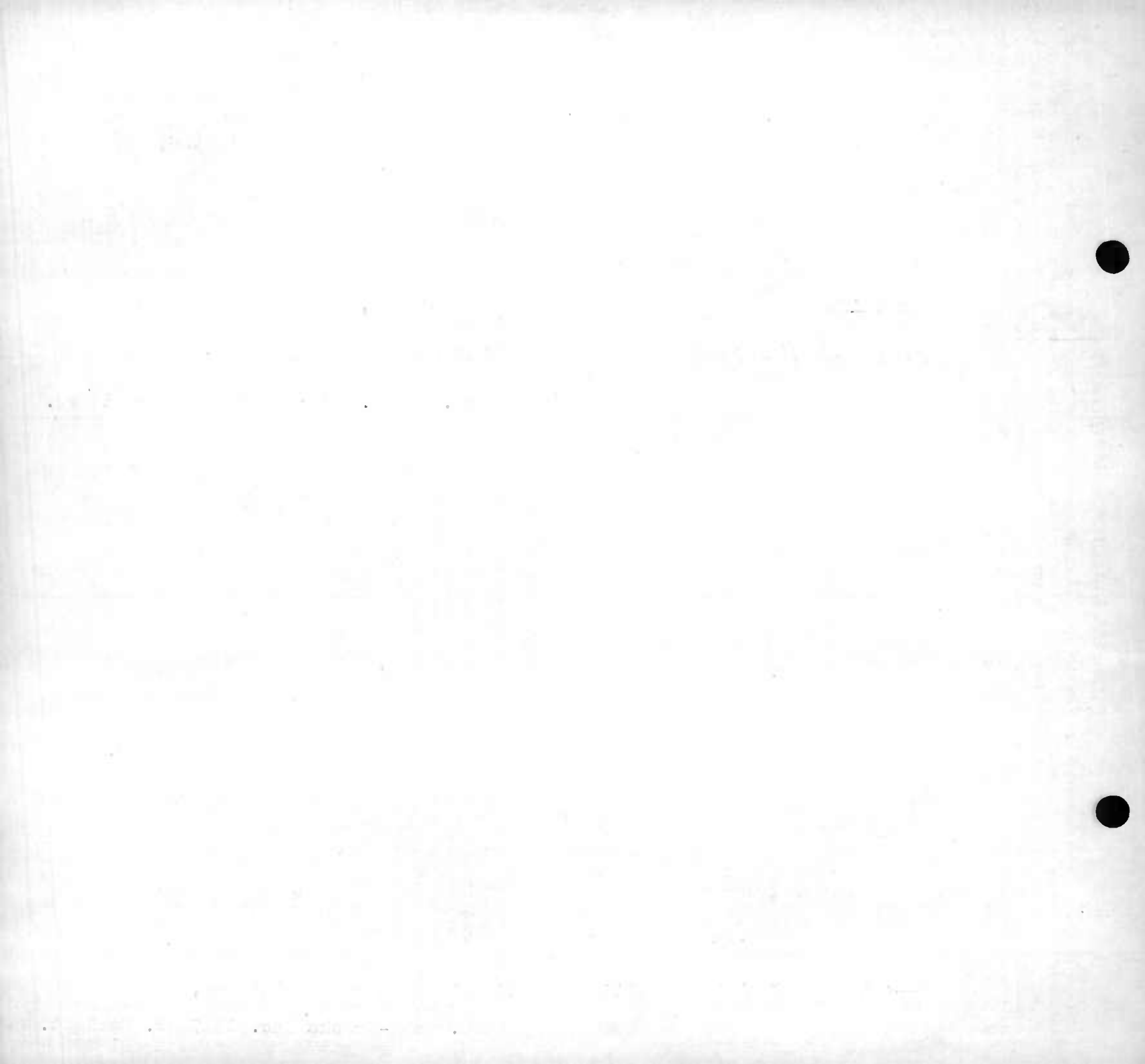
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 6328		65 6328	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) DORIS ROSE CRAHER			2. DATE AND HOUR OF DEATH JUNE 15, 1965 1:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSPITAL			A. STATE MARYLAND B. COUNTY 9-06		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 1714 E. 29th St. #18		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-1-04	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEPHONE OPERATOR			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Boston Mass.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME ? Shaw		
14. MOTHER'S MAIDEN NAME Bertha TANNER			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 212-22-6896			17. INFORMANT ADDRESS HOSPITAL RECORDS MONTEBELLO		
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma, Breast to metastases			4 years		
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 2, 1965 to June 15, 1965 , that (I) (we) last saw the deceased alive on June 15, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Elsa R. Merani, MD				23B. DATE SIGNED 6/15/65	
23C. PHYSICIAN'S NAME (Type) Elsa R. Merani M.D.				23D. ADDRESS Montebello State Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/18/65		24C. NAME of CEMETERY or CREMATORY Mt. Olivet Cemetery	
24D. LOCATION (City, town, or county) (State) Fredrick, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUN 17 1965		25B. NAME OF REGISTRAR Robert E. Jakes, Jr.		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. 1217 St. Paul St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

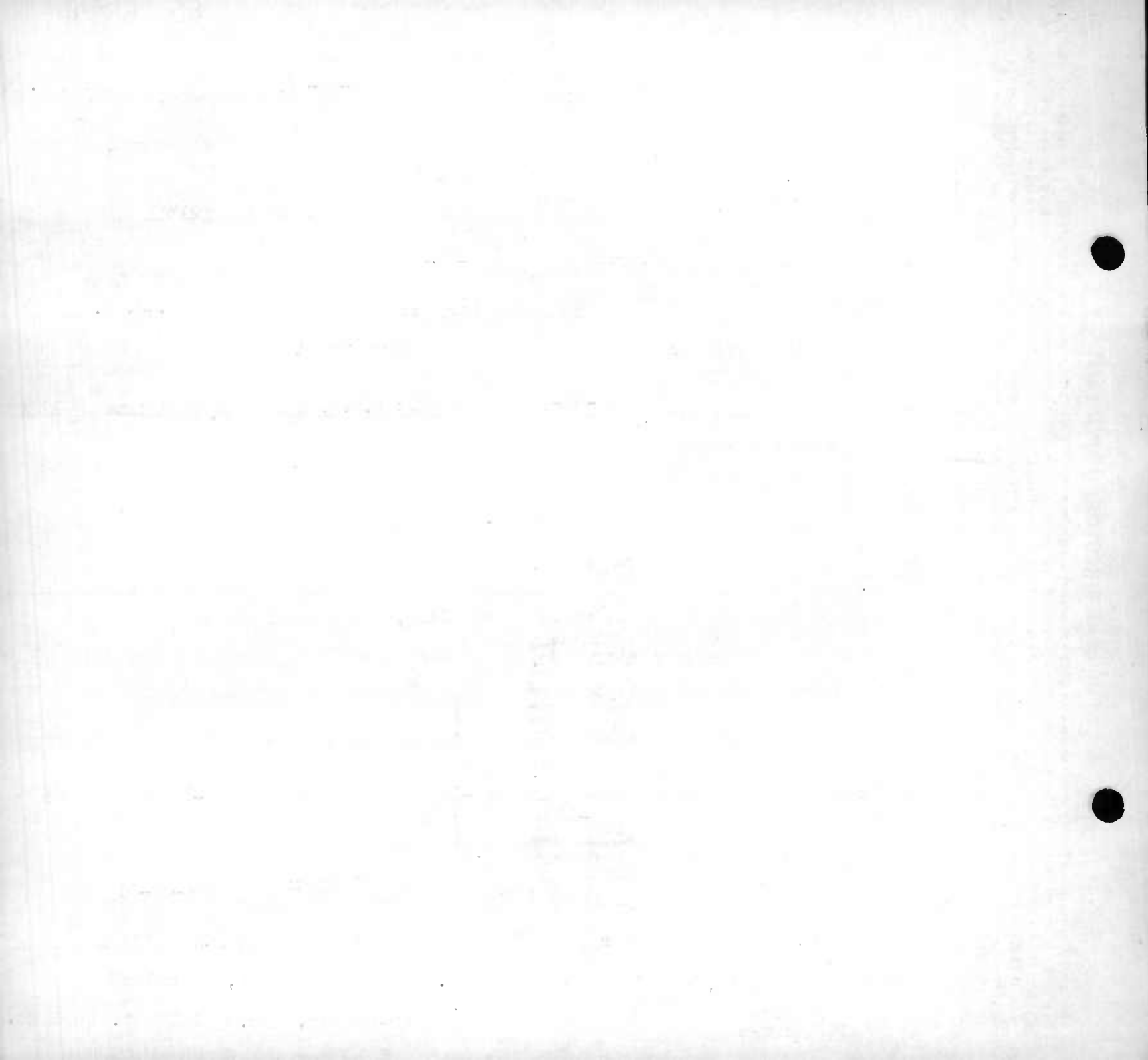
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 6329		65 6329			
M.E. CASE NO.		6-14-65			
1. NAME OF DECEASED (Type or Print) O'BRIEN, LAURA M		2. DATE AND HOUR OF DEATH 6-14-65 12 2 ³⁰ AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND JOHN'S HOPKINS HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 9-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3801 GREENMOUNT AVE #18			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 12-2-87	9. AGE (In years last birthday) 78	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN J. MEYER		14. MOTHER'S MAIDEN NAME LAURA M. MORLING	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Nan E. Myer 3801 Greenmount Ave.	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ? Sepsis DUE TO (B) Gangrenous L. 1 st toe DUE TO (C) Diabetes		INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 wk Several Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/12 19 65 to 6/14 19 65, that (I) (we) last saw the deceased alive on 6/14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David Golden RB,		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/14/65	
23C. PHYSICIAN'S NAME (Type) DAVID GOLDEN RB,		23D. ADDRESS JOHN'S HOPKINS HOSPITAL, BALTO., MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/17/65		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 17 1965			
25B. NAME OF REGISTRAR Robert E. Fadden		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. 1217 St. Paul St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

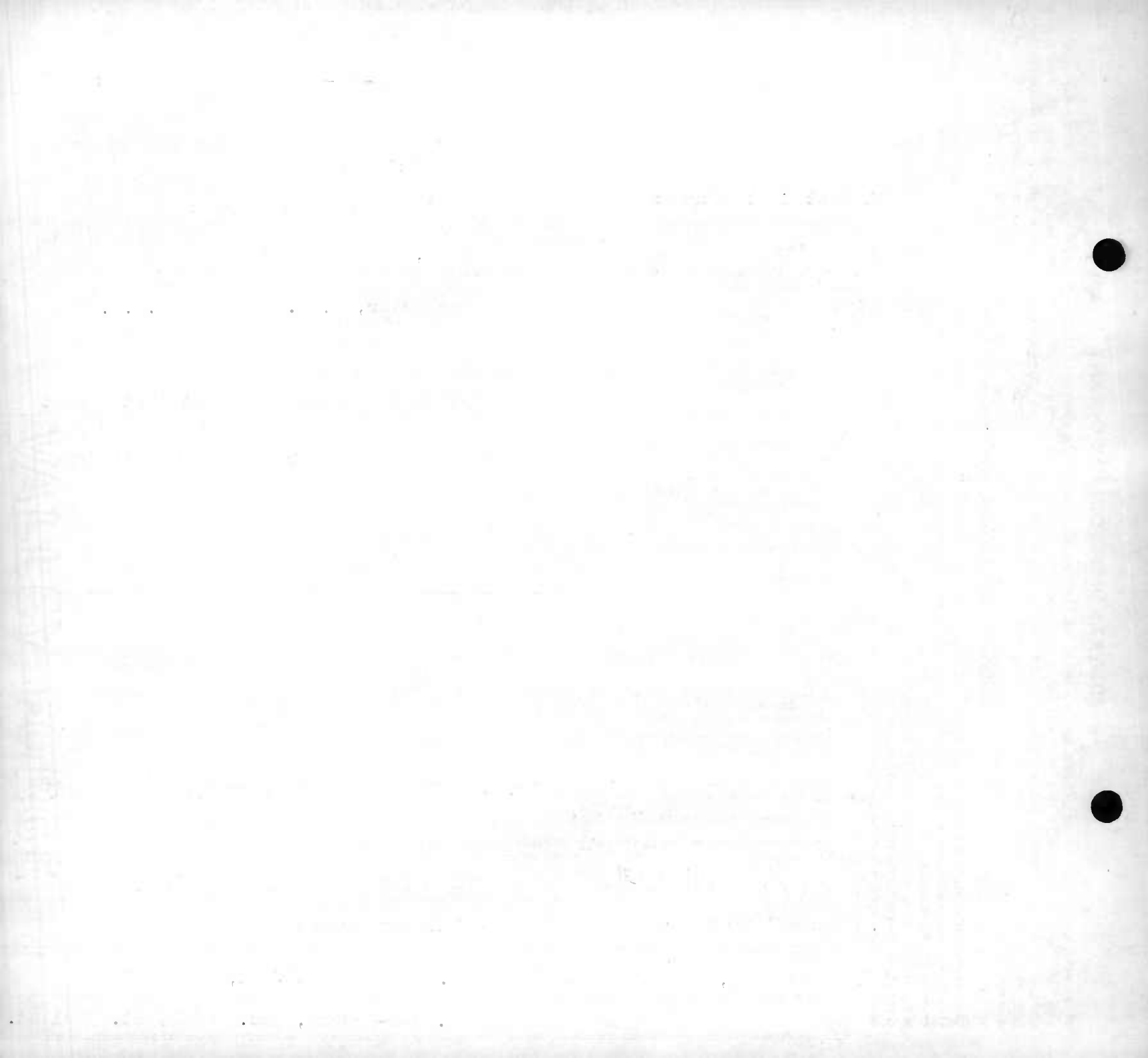
43-63-39 AM		65 6330		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6330	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print)				6-12-65 11:15 A.M.			
John Atkinson							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2845 Huntingdon Avenue #21211			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
Male	White	Divorced	6-19-05	59			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Salesman				Maryland		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Atkinson				Cora Kraft			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		218-05-7480		RECORDS: B.C.H. 4940 Eastern Avenue #21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Subarachnoid Hemorrhage			
ANTECEDENT CAUSES				(B) Metastatic Carcinoma of the Lung			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II				Chronic Alcoholism, Emphysema, Osteoarthritis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 5-18-1965 to 6-12-1965, that (I) (we) last saw the deceased alive on 6-12-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Dr. Charles Carpenter						6-12-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				4940 Eastern Avenue #21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		June 16, 65		New Cathedral Cem.		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 17 1965		E. F. F. F.		Wm Cook-Brooks, Inc.		1217 St. Paul St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 6331		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 6331	
M.E. CASE NO.				1. NAME OF DECEASED				2. DATE AND HOUR OF DEATH	
(Type or Print)				MARY ANN BAKER				6-15-65 3:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland				B. COUNTY 12-05	
21 East 21st Street				C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Baltimore	
				D. STREET ADDRESS (If rural, give location)				21 East 21st Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Female	White	Married		May 17, 1916	49	Housewife		Rochester, N. Y.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
								U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No						Arthur Lee Baker 21 East 21st Street			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) carcinoma cervix uteris				13 months	
ANTECEDENT CAUSES				(B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				no					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from November 18, 1964 to June 15, 1965, that (I) (we) last saw the deceased alive on May 28, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
E. Ellsworth Cook								6/15/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
E. Ellsworth Cook				2431 Maryland Avenue					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		June 17, 65		New Cathedral Cem.		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUN 17 1965		R. E. Faldut		Wm. Cook-Brooks, Inc.		1217 St. Paul St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in hospital and the body was released to the hospital by a medical examiner. Also, if the direct or indirect cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6332		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6332	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Freddie Cosby		2. DATE AND HOUR OF DEATH 6-15-65 4:35P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 8-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1817 N. Broadway			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 3-23-93	9. AGE (In years last birthday) 72	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Buckingham Co. VA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Philip Brown		14. MOTHER'S MAIDEN NAME Lu Sidney Wade	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT A. WATKINS 1817 N. Franklin	
18. 45-1X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Dissecting Anurysm DUE TO (B) Essential Hypertension DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) -Yes- NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-13-65 19 to 6-15-65 19, that (I) (we) last saw the deceased alive on 4:30 PM 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Steve L. Johnson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-15-65	
23C. PHYSICIAN'S NAME (Type) Steve L. Johnson		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-19-65		24C. NAME of CEMETERY or CREMATORY Glendale Cem.	
24D. LOCATION Bloomfield		(City, town, or county) (State) N. J.			
25A. DATE REC'D BY HEALTH DEPT. JUN 17 1965		25B. NAME OF REGISTRAR R. E. F. F.		25C. FUNERAL DIRECTOR MORTON & Dye II 1701 LAURENS ST.	

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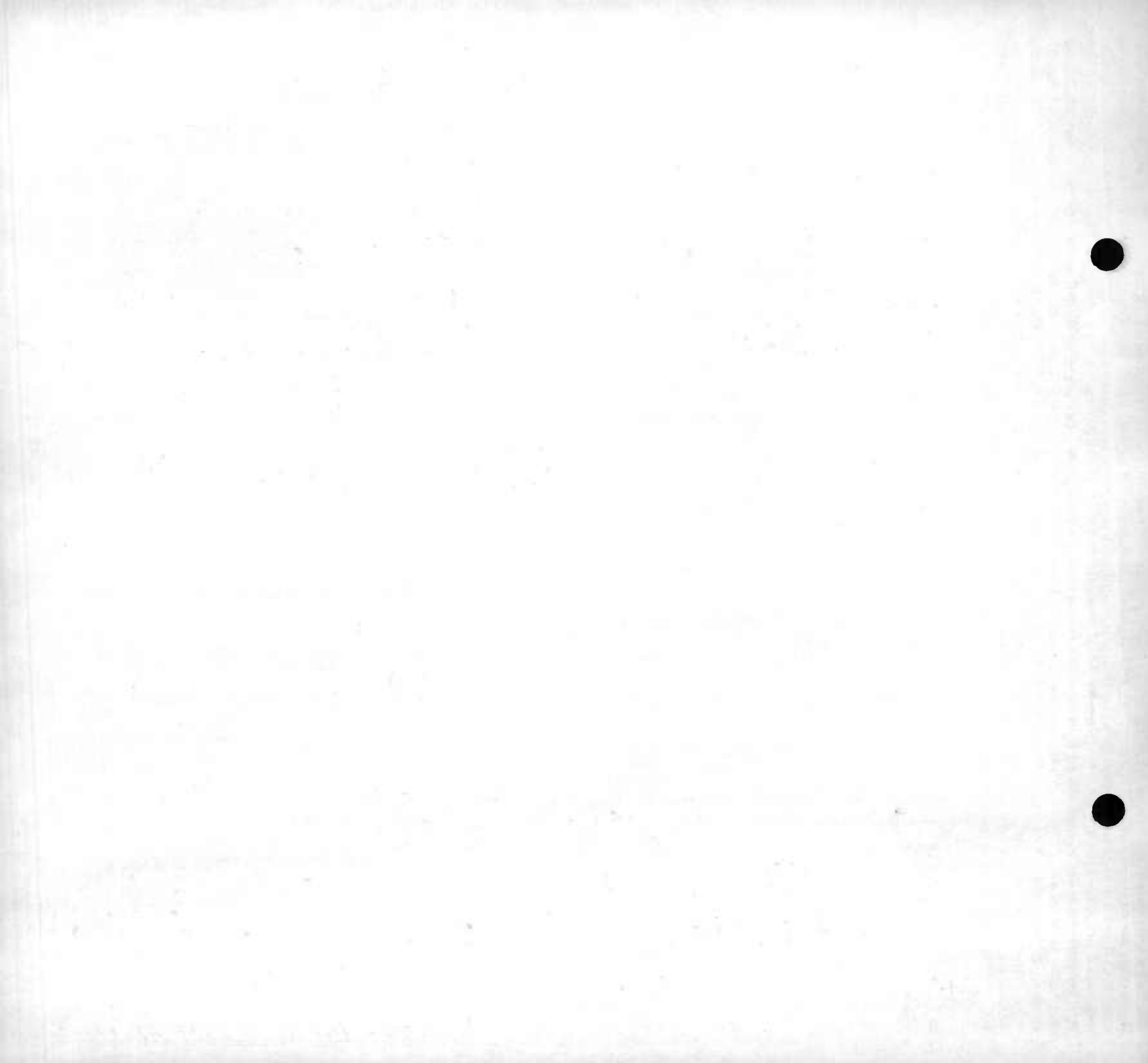
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1917-1918

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

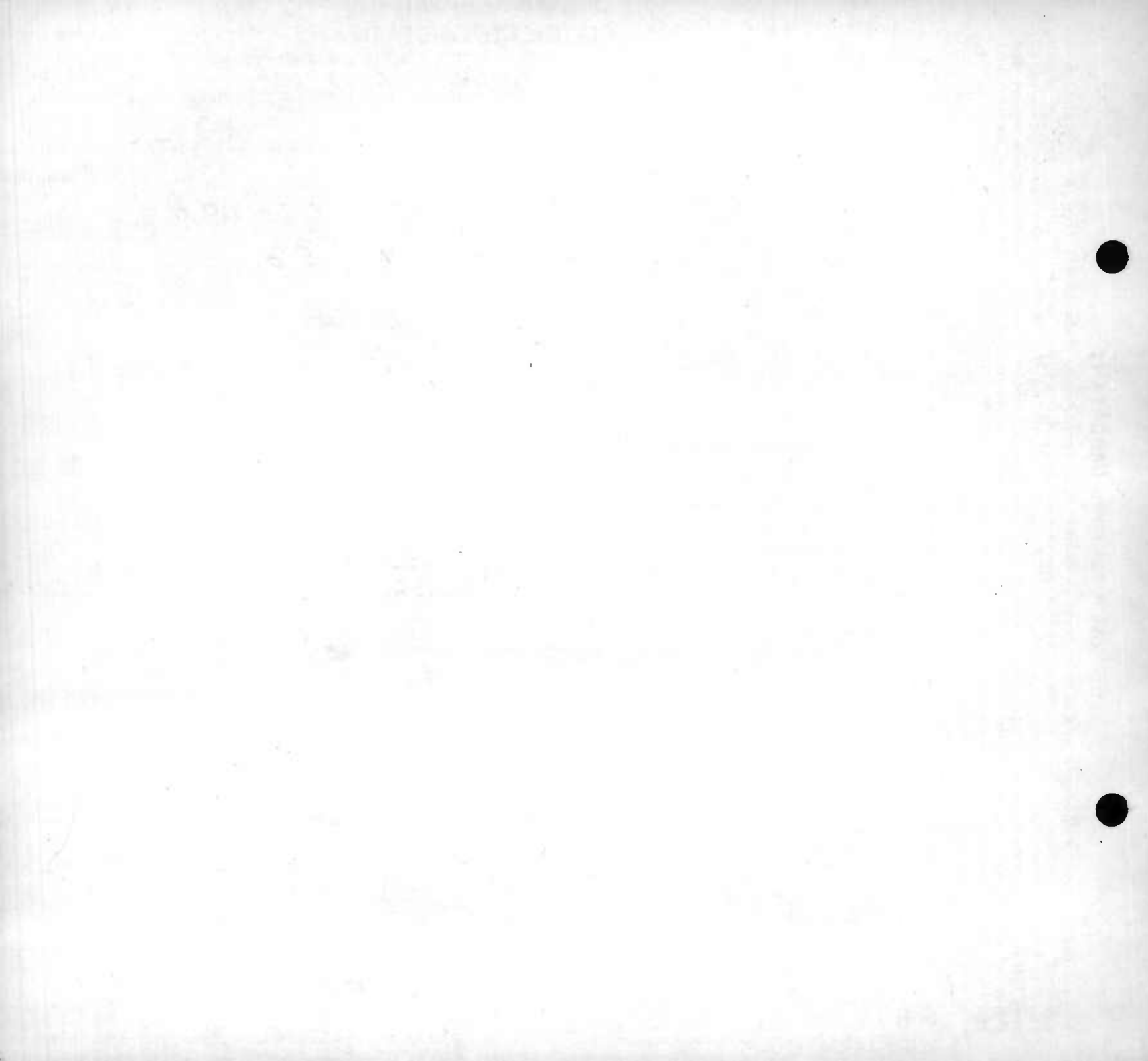
BIRTH NO. 65 6333		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6333	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Ray, ELLA Susan		2. DATE AND HOUR OF DEATH 6-16-65 3 ¹⁴ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		A. STATE Md.			
(If not in hospital or institution, give street address or location)		B. COUNTY 16-04			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. #17			
		D. STREET ADDRESS (If rural, give location) 1112 McKean Ave #17			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7/27/09	9. AGE (In years last birthday) 55	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Elmer Dixon			14. MOTHER'S MAIDEN NAME - Lucinda MARTIN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT Robert E. Stoner, M.D.	
				ADDRESS University Hospital	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 2-30-61 to 6-16-65, that (1) (we) last saw the deceased alive on 6-16-65 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did not) view the body after death.					
23A. SIGNATURE Robert E. Stoner, M.D.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-16-65	
23C. PHYSICIAN'S NAME (Type) Robert E. Stoner		23D. ADDRESS University Hospital Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE	24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem. A.A. Co		24D. LOCATION (City, town, or county) (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 17 1965		25B. NAME OF REGISTRAR Robert E. Stoner		25C. FUNERAL DIRECTOR MORTON + DYETT	
				ADDRESS 1701 Laurens	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

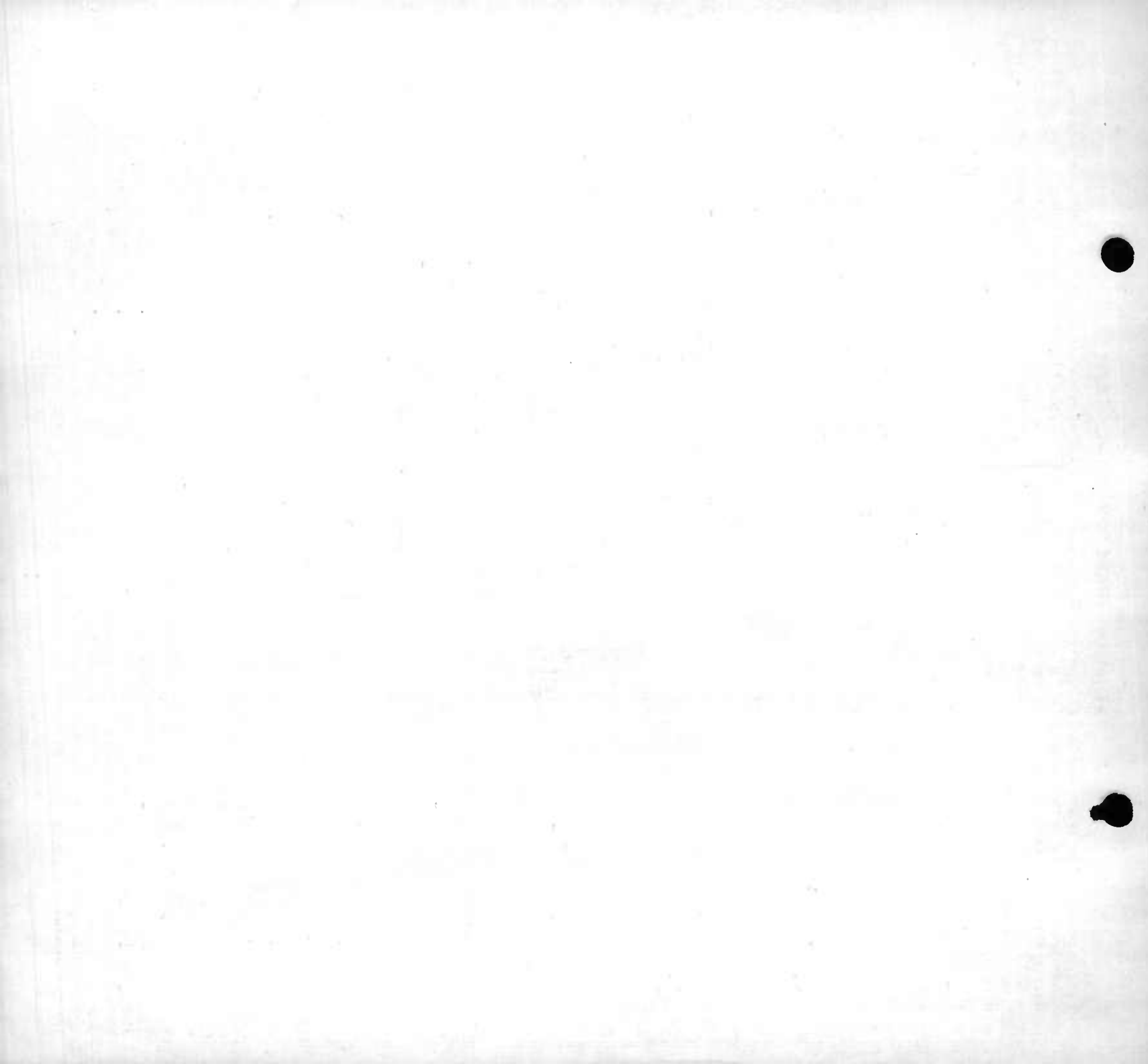
BIRTH NO. 65 6334		BALTIMORE CITY DEPARTMENT		Registered No. 65 6334	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Lilly Ann Morton (Lillie)</i>		2. DATE AND HOUR OF DEATH <i>6-16-65 5:45 A.M.</i>	
3. PLACE OF DEATH <i>IN BALTIMORE, MARYLAND</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>15-03</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>The Hospital For the Women of Maryland</i>		D. STREET ADDRESS (If rural, give location) <i>2102 Westwood Ave</i>			
5. SEX <i>Female</i>	6. RACE <i>negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>2-11-07</i>	9. AGE (In years last birthday) <i>58</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>William A. Bruce</i>		14. MOTHER'S MAIDEN NAME <i>Link</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unknown</i>		16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT <i>Patients chart</i>	
18. 023X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Gangrene of small intestine artery</i> (B) <i>Mesenteric thrombosis</i> (C) <i>Aortic insufficiency due to Luas & CHF. & atrial fibrillation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>30 years</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-14 1965</i> to <i>6-16 1965</i> , that (I) (we) lost the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joo-Kei Chow</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6-16-65</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>6-20-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 17 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>Morton & Zett Funeral Home</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6335	
BIRTH NO.		CERTIFICATE OF DEATH			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Charles Richard Brown		June 16, 1965		10:35 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital 1514 Division Street Baltimore, Maryland 21217		A. STATE Maryland		B. COUNTY 12-07	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		120 W. 21st. Street	
5. SEX Male	6. RACE negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Feb. 10, 1904	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10B. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME unknown Richard Brown		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-03-7855		17. INFORMANT Margaret Brown-wife	
		ADDRESS same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Terminal Carcinoma of Stomach DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
19. DATE OF OPERATION 0					
20A. AUTOPSY? (Yes or No) no					
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 14, 1965 to June 16, 1965, that (I) (we) last saw the deceased alive on June 16, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Theodore		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 16, 1965	
23C. PHYSICIAN'S NAME (Type) R. Theodore		23D. ADDRESS M.D. 1514 Division Street. - Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/21/65	24C. NAME of CEMETERY or CREMATORY Mt Auburn	24D. LOCATION BALT., Md.		
25A. DATE REC'D BY HEALTH DEPT. JUN 17 1965	25B. NAME OF REGISTRAR R. E. F. F. F.	25C. FUNERAL DIRECTOR Morton & Dept	ADDRESS 1701 Laurens ST.		



FUNERAL DIRECTOR: IMPORTANT

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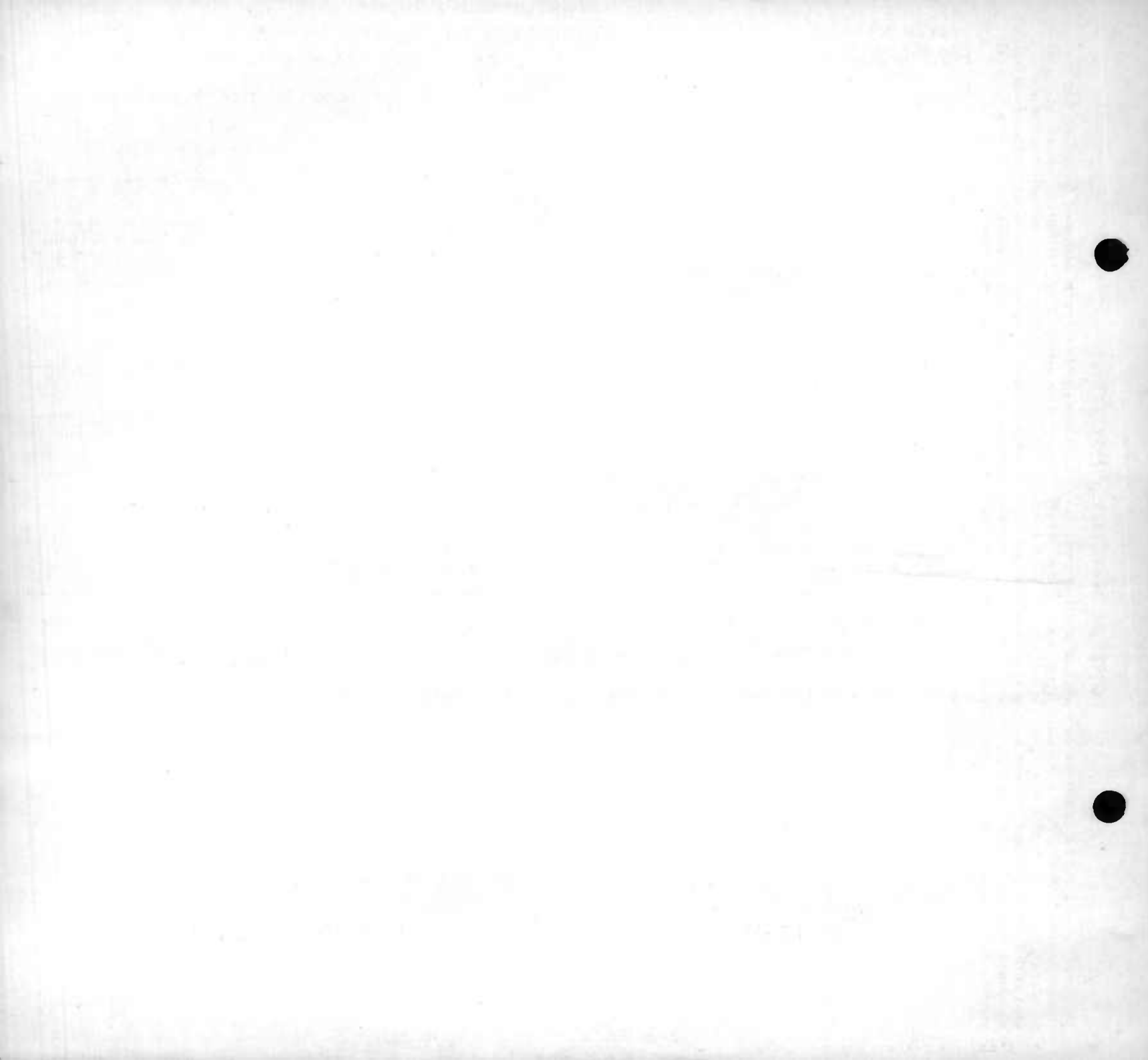
BIRTH NO. 65 6336		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6336		4
M.E. CASE NO.		CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) Phyllis Denise Ebersole		2. DATE AND HOUR OF DEATH June 9, 1965 12:50 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION Md. Gen Hosp.		A. STATE Md. B. COUNTY 13-05				
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BAKTO #11				
		D. STREET ADDRESS (If rural, give location) 3111 ELM Ave				
5. SEX Female	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) N.B.	8. DATE OF BIRTH June 7, 1965	9. AGE (In years last birthday) 13-05	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stephen Charles ELZO			14. MOTHER'S MAIDEN NAME Jean Marie Ebersole			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mother	
18. 2773.61 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Hyaline Membrans Prematurity.			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO			
			(B) DUE TO			
			(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 6-7-65 19 to 6-9-65 19, that (I) (we) last saw the deceased alive on 6-9-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE R. Casas		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 6-9-65	
23C. PHYSICIAN'S NAME (Type) ROBERTO CASAS		23D. ADDRESS Md. Gen Hosp.				
24A. BURIAL CREMATION REMOVAL (Specify) JUN 10 1965		24B. DATE		24C. NAME of CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHP		
24D. LOCATION (City, town, or county) (State)						
25A. DATE REC'D BY HEALTH DEPT. JUN 17 1965		25B. NAME OF REGISTRAR R. Casas		25C. FUNERAL DIRECTOR ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

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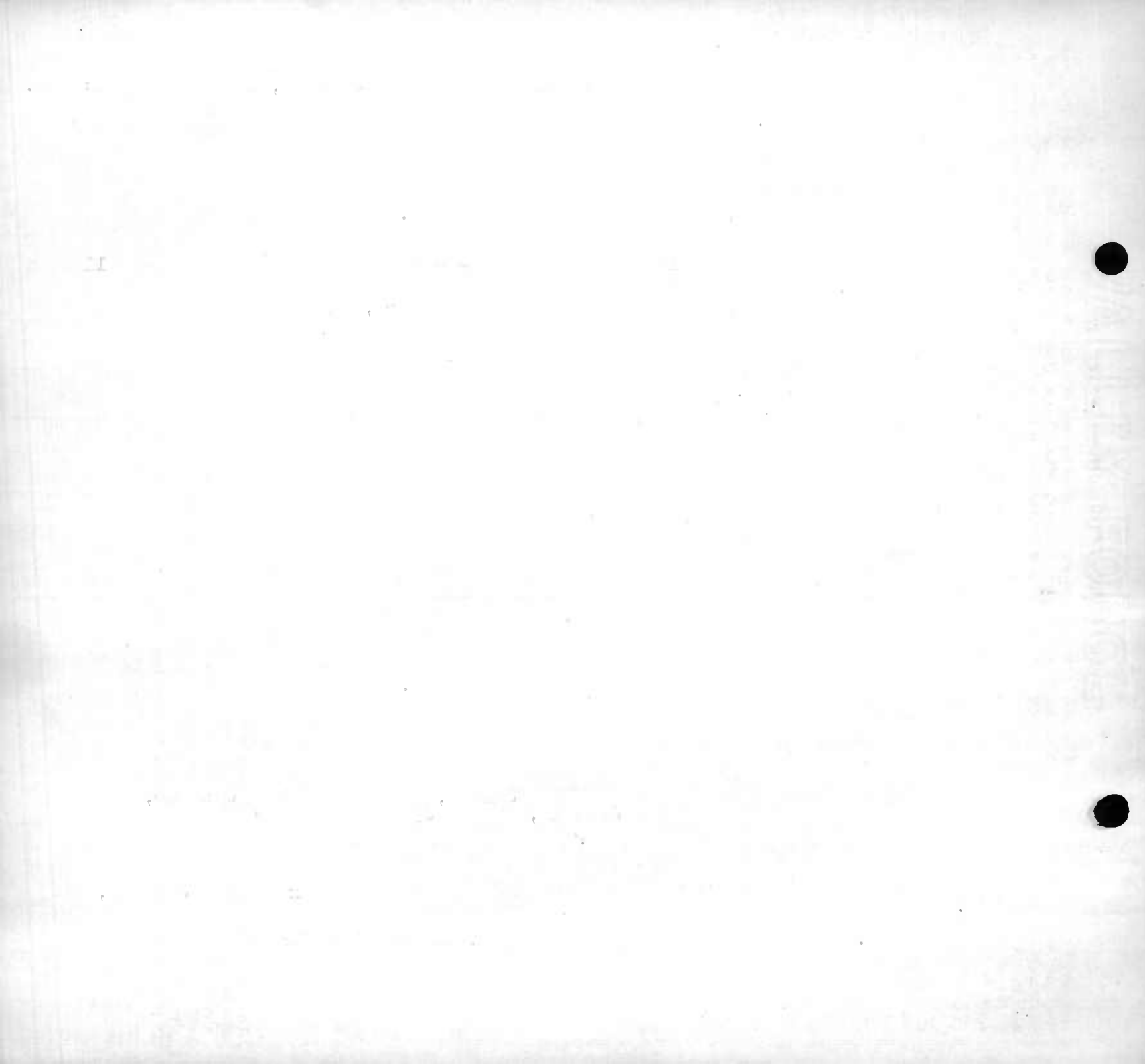
P-4601		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6337	
BIRTH NO. 65-13918 65 6337		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby boy POEHLER		2. DATE AND HOUR OF DEATH 6-8-1965 12.30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 9-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2706 Mathews st			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 6-8-65	9. AGE (In years last birthday) 24	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 3
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U.S.A. Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME MR. CLARENCE POEHLER		14. MOTHER'S MAIDEN NAME KATHLEEN NORRIS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Parents ADDRESS Same	
18. 760.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) prematurity DUE TO (B) respiratory failure DUE TO (C) Brain damage.		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 3 min.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-7-65 19 to 6-8 1965, that (I) (we) last saw the deceased alive on 6-8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE IRAY NEJAT		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-8-65	
23C. PHYSICIAN'S NAME (Type) IRAY NEJAT		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) JUN 15 1965		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND	
24D. LOCATION UNIVERSITY MEDICAL SCHOOL		24E. LOCATION (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 17 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	
25D. ADDRESS		25E. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65-1541465 6338		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6338	
1. NAME OF DECEASED (Type or Print) Baby of Margaret Jackson			2. DATE AND HOUR OF DEATH June 10, 1965 1:00 a.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2213 W. Baltimore Street		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 6-9-65	9. AGE (In years last birthday) 12	If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Larry Jackson			14. MOTHER'S MAIDEN NAME Margaret Mashburn		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 763.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Prematurity			CAUSE OF DEATH (A) intracranial bleeding DUE TO (B) Pneumonia DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 9, 1965 to June 10, 1965, that (I) (we) last saw the deceased alive on June 10, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Behrooz			23B. DATE SIGNED June 11, 1965		
23C. PHYSICIAN'S NAME (Type) M. Behrooz			23D. ADDRESS 1514 Division Street		
24A. BURIAL CREMATION, REMOVAL (Specify) JUN 15 1965		24B. DATE JUN 15 1965		24C. NAME of CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND	
24D. LOCATION UNIVERSITY MEDICAL SCHOOL		24E. ADDRESS MORTUARY SERVICE - BCHD		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. JUN 17 1965		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR	



BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 6339 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 6339

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) MARGARET WILLIAMS		2. DATE AND HOUR PRONOUNCED DEAD 5-30-65 10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore B. COUNTY Harford	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 92 BALTIMORE CITY JAIL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
D. STREET ADDRESS (If rural, give location) 10-03			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
9. AGE (In years lost birthday) 35		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
(A) DUE TO FATTY INFILTRATION OF LIVER			
(B) DUE TO CHRONIC ETHYLISM			
(C) DUE TO			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. S. FISHER EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 5-31-65			
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE JUN 17 1965	23C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL	
24A. DATE REC'D BY HEALTH DEPT. JUN 17 1965		24B. NAME OF REGISTRAR John E. Fisher	
24C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		ADDRESS	

VALLEY FORGE

RECORDS

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65 6340 BALTIMORE CITY HEALTH DEPARTMENT 65 6340

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) CLIFORD EUGENE NAYLOR (Ronald L. Davis)

2. DATE AND HOUR PRONOUNCED DEAD May 17, 1965 3:43 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-01

D. STREET ADDRESS (If rural, give location) 112 E. Preston Street

5. SEX Male

6. RACE Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years last birthday) 47

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE John E. Adams, M.D.

EXAMINER'S NAME (Type) John E. Adams, M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

ASSOCIATE MEDICAL EXAMINER

DATE SIGNED 5-19-65

23A. BURIAL CREMATION, REMOVAL (Specify)

23B. DATE JUN 17 1965

23C. NAME OF CEMETERY OR CREMATORY

23D. LOCATION (City, town or county) (State)

24A. DATE REC'D BY HEALTH DEPT. JUN 17 1965

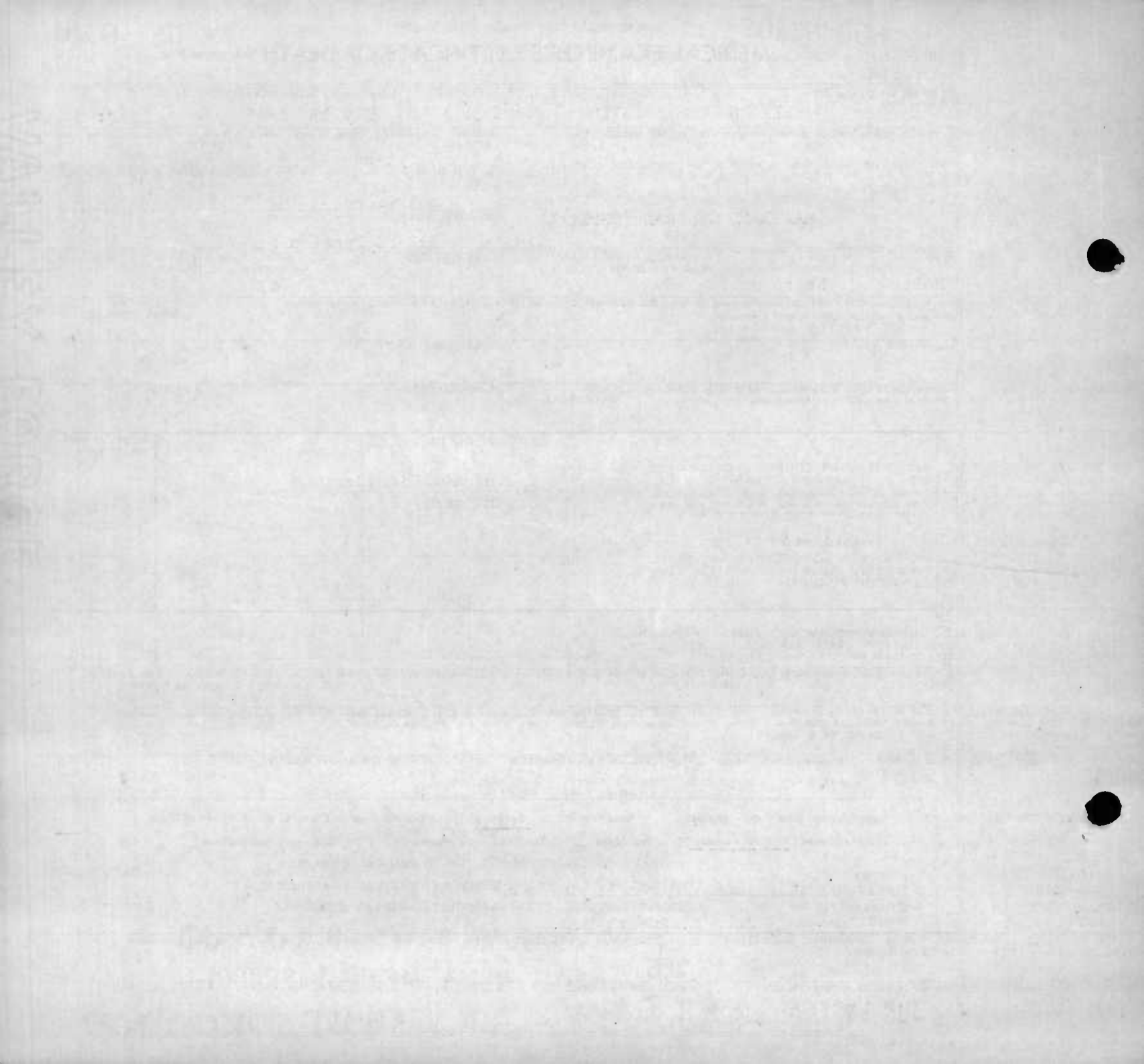
24B. NAME OF REGISTRAR Robert E. Fairley

24C. FUNERAL DIRECTOR

24D. ADDRESS

MORTUARY SERVICE - BCHD

VS 151-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

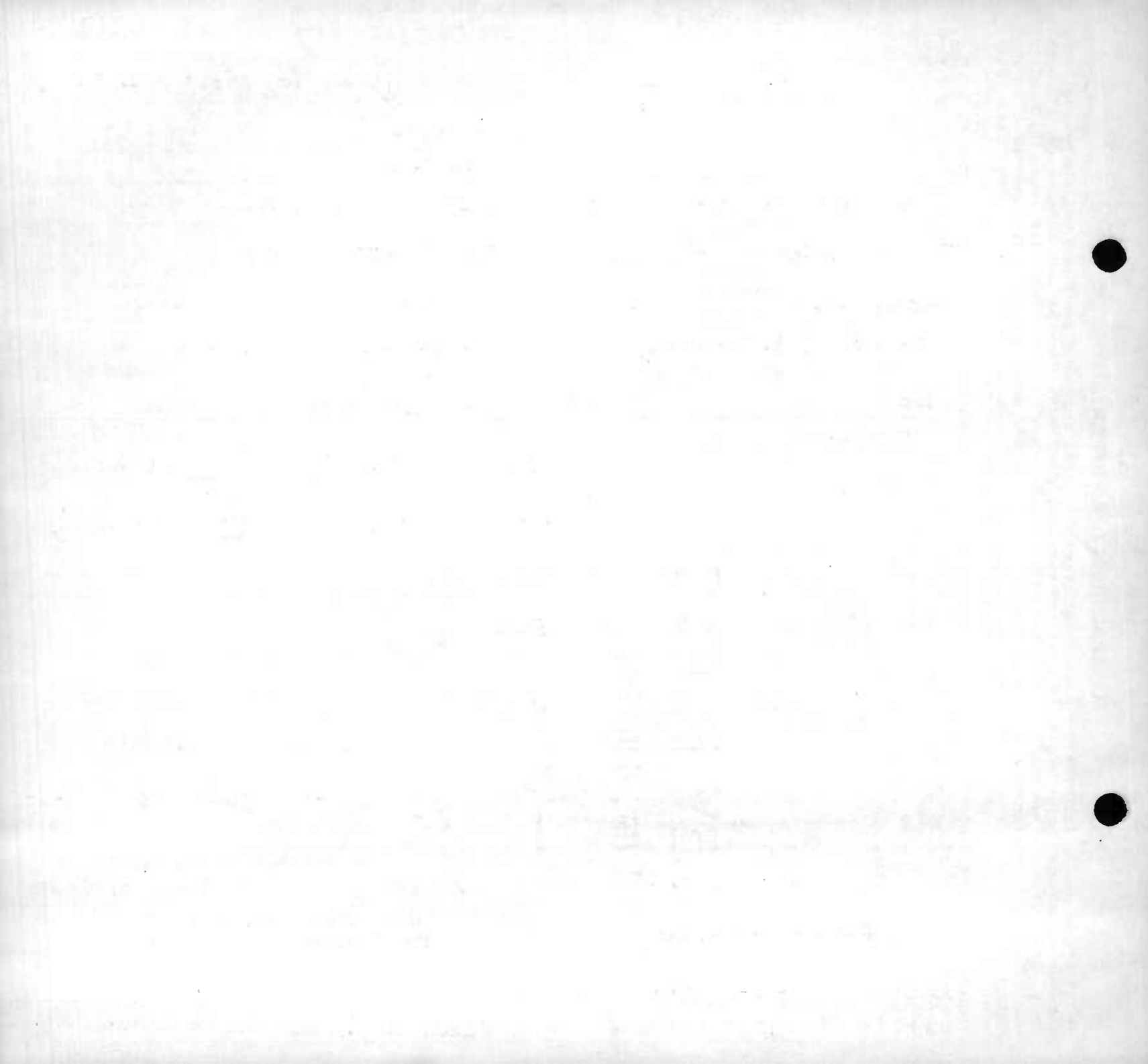
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6341	
BIRTH NO. 65 6341				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) George Watkins			2. DATE AND HOUR OF DEATH 6-12-65 12:50 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bar-Wil-Ba Convalescent Home			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 7-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1710 E. Madison St.		
5. SEX M.	6. RACE Col.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH 3-11-1893	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10B. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Windsboro, S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John Watkins		
14. MOTHER'S M maiden name UNKNOWN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. XX?			17. INFORMANT Mrs Willie Knight 1710 E. Madison St.		
18. 430.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-24-1964 to 6-12-1965 , that (I) (we) last saw the deceased alive on 6-11-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE C.R. Campbell				23B. DATE SIGNED 6-12-65	
23C. PHYSICIAN'S NAME (Type) C.R. Campbell				23D. ADDRESS M.D. 1618 W. North Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-16-65		24C. NAME of CEMETERY or CREMATORY McCalvary Cemetery	
24D. LOCATION Anne Arundel Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 17 1965			
25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Randolph J. Collick 1412 E. Preator St.			

101 Col 11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

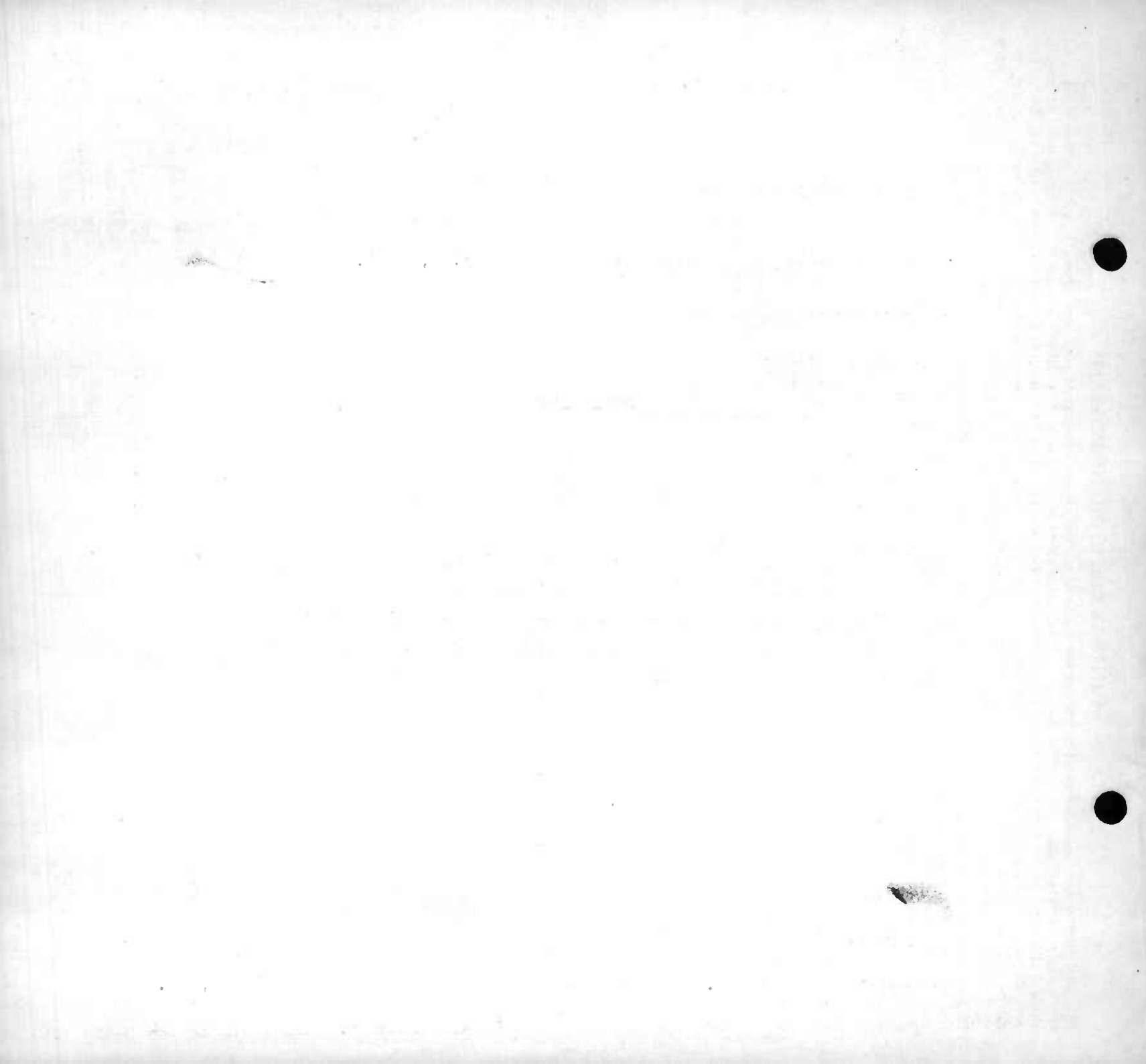
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6342	
BIRTH NO. 65 6342		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Jenny Anniko</i>		2. DATE AND HOUR OF DEATH <i>June 16, 1965 4:40 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>2890 Pelham Ave. Baltimore, Md. 21213</i>		A. STATE <i>Maryland</i> B. COUNTY <i>27-01</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>2890 Pelham Ave.</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED , DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>Sept. 5, 1877</i>	9. AGE (In years last birthday) <i>87</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Estonia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>Estonia</i>		13. FATHER'S NAME <i>Friedrich Laurberg</i>		14. MOTHER'S MAIDEN NAME <i>Alexandra Lilienthal</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT ADDRESS <i>Mrs Anna Paabo same</i>	
18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <i>EVA - Hemorrhage</i> DUE TO (B) <i>Arteriosclerotic Hypertensive cardiovascular disease</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i> <i>24 years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Old age</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1941</i> to <i>June 16, 1965</i> , that (I) (we) last saw the deceased alive on <i>June 16, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Paul H. Anniko</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>June 16, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>PAUL H. ANNIKO</i> M.D.				23D. ADDRESS <i>3800 ERDMAN AVE. BALTIMORE, MD. 21213</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>cremation</i>	24B. DATE <i>6-21-65</i>	24C. NAME of CEMETERY or CREMATORY <i>Greenmount Crematorium</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 17 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck Inc Baltimore, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

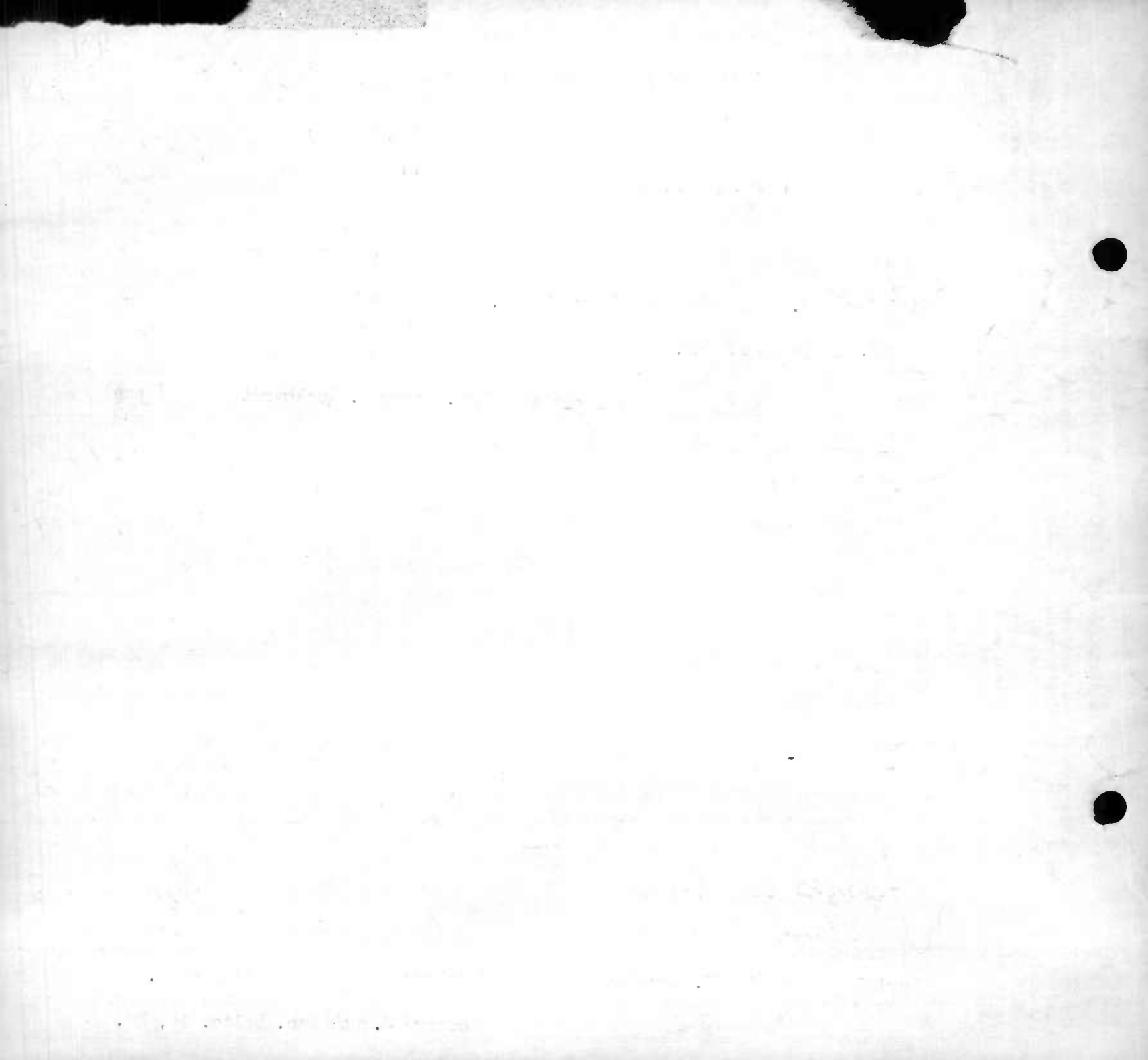
BIRTH NO. 65 6343		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6343	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Eugene J. Halvey		2. DATE AND HOUR OF DEATH June 15, 1965 5:00 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3734 Old York Road		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 9-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #18 D. STREET ADDRESS (If rural, give location) 3734 Old York Road			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Jan. 4, 1901.	9. AGE (In years lost birthday) 64	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Typographer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Halvey		14. MOTHER'S MAIDEN NAME Bridoid	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 099-14-4148		17. INFORMANT Elizabeth V. Halvey	
18. 527.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Heart Disease. Ch. Diverticular ulcer		CAUSE OF DEATH (A) DUE TO Pulmonary emphysema Ch. Pulmonary (B) DUE TO Bronchopneumonia Terminal (C) Arteriosclerotic Heart Disease. Ch. Diverticular ulcer		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 6/13 1965 to 6/15 1965, that (I) (we) last saw the deceased alive on 6/13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Donald W. Mintzer		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/16/65	
23C. PHYSICIAN'S NAME (Type) DONALD W. MINTZER		23D. ADDRESS M.D. 3009 EVERGREEN AVE BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/19/65.		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 17 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

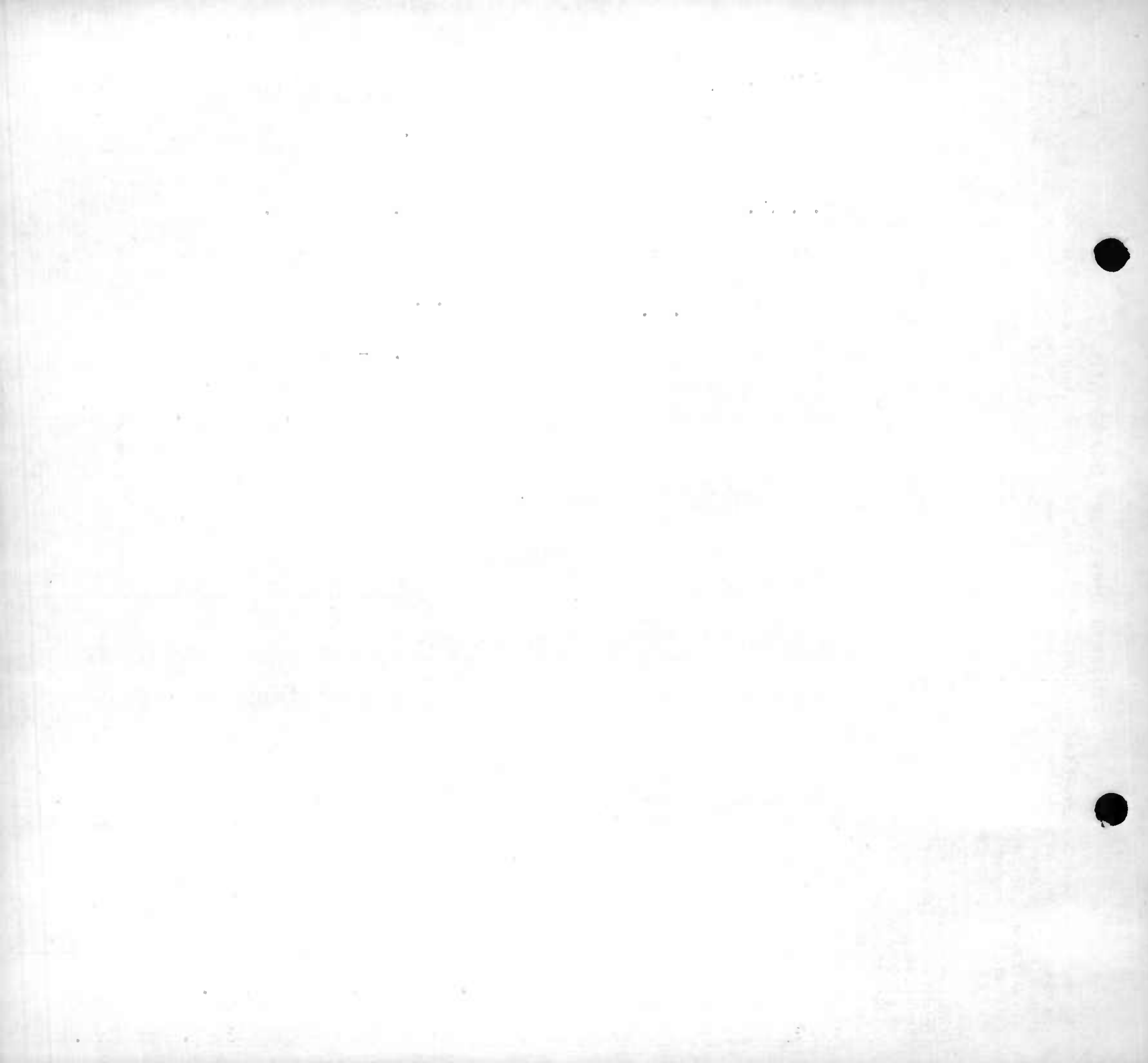
BALTIMORE CITY HEALTH DEPARTMENT									
65 6344					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Luckhardt, John W. Jr.					6-15-65 3:20 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
33 JOHNS HOPKINS HOSPITAL					MARYLAND				
5. SEX MALE					6. RACE WHITE				
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED					8. DATE OF BIRTH MARCH 17, 1911				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY				
Division Mgr.					Commerical Credit Co.				
13. FATHER'S NAME JOHN W. LUCKHARDT SR.					14. MOTHER'S MAIDEN NAME KATHERINE CARTER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
Yes WW 2					215-05-2855				
17. INFORMANT Mrs. Nancy E. Luckhardt					ADDRESS (Same)				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
331X+201X					Pneumonia				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CVA				
Hodgkin's Disease					Interval Between Onset and Death 24 hr. 67 days				
19A. DATE OF OPERATION 2					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) YES					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from April 10, 1965 to June 15, 1965, that (I) (we) last saw the deceased alive on June 15, 1965, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					23A. SIGNATURE James W. Keller				
23B. PHYSICIAN'S NAME (Type) James W. Keller					23C. ADDRESS Johns Hopkins Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 6/18/65				
24C. NAME of CEMETERY or CREMATORY Moreland Memorial Cemetery					24D. LOCATION (City, town, or county) (State) Baltimore Md.				
25A. DATE REC'D BY HEALTH DEPT. JUN 17 1965					25B. NAME OF REGISTRAR Robert E. Taylor				
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. 14, Md.					ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6345				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6345	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) John H. Layne				2. DATE AND HOUR OF DEATH 6/16/65 1 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) S.B.G.H.				A. STATE Md. B. COUNTY 23-02			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				D. STREET ADDRESS (If rural, give location) 58 E. Randall St.			
5. SEX M	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/12/04	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		10B. KIND OF BUSINESS OR INDUSTRY W.Md. RR		11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Floyd Layne				14. MOTHER'S MAIDEN NAME Mary E. -			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH A. DUE TO Coronary Occlusion B. DUE TO Arterio Sclerotic Heart Disease C. DUE TO INTERVAL BETWEEN ONSET AND DEATH							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Raynaud's Phenomenon Pulmonary Embolism							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2/6/1963 to 6/16/1965, that (I) (we) last saw the deceased alive on 6/3/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE H.P. Friedman				M.O. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/16/65	
23C. PHYSICIAN'S NAME (Type) H.P. FRIEDMAN				23D. ADDRESS M.D. 1319 LIGHT ST.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/19/65		24C. NAME OF CEMETERY or CREMATORY Union Memorial Cem.		24D. LOCATION (City, town, or county) (State) Cumberland, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR McCully Funeral Home		ADDRESS 130 E. Fort Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6346	
BIRTH NO. 65 6346		CERTIFICATE OF DEATH			
M.E. CASE NO. GEARE					
1. NAME OF DECEASED (Type or Print) Geare, Ida		2. DATE AND HOUR OF DEATH 6/16/65 1:35 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sina Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto D. STREET ADDRESS (If rural, give location) 2602 Boardman Ave			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 3-4-1912	9. AGE (In years lost birthday) 53	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME LOUIS		14. MOTHER'S MAIDEN NAME SERAN		17. INFORMANT ADDRESS Hospr Chert	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 225-10-0728			
18. 443X-260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus		CAUSE OF DEATH (A) CVA DUE TO (B) HASCVD DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/16/65 9:30 AM to 6/16/65 3:15 PM , that (I) (we) last saw the deceased alive on 6/16/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas L. Fisher		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/16/65	
23C. PHYSICIAN'S NAME (Type) Thomas L. Fisher		23D. ADDRESS Sina Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6/18/1965	24C. NAME OF CEMETERY or CREMATORY ROSEDALE		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR ADDRESS SYLVAN S. LEWIS & SON, INC. - 3319 OLYMPIA AVE	

FUNERAL DIRECTOR: IMPORTANT

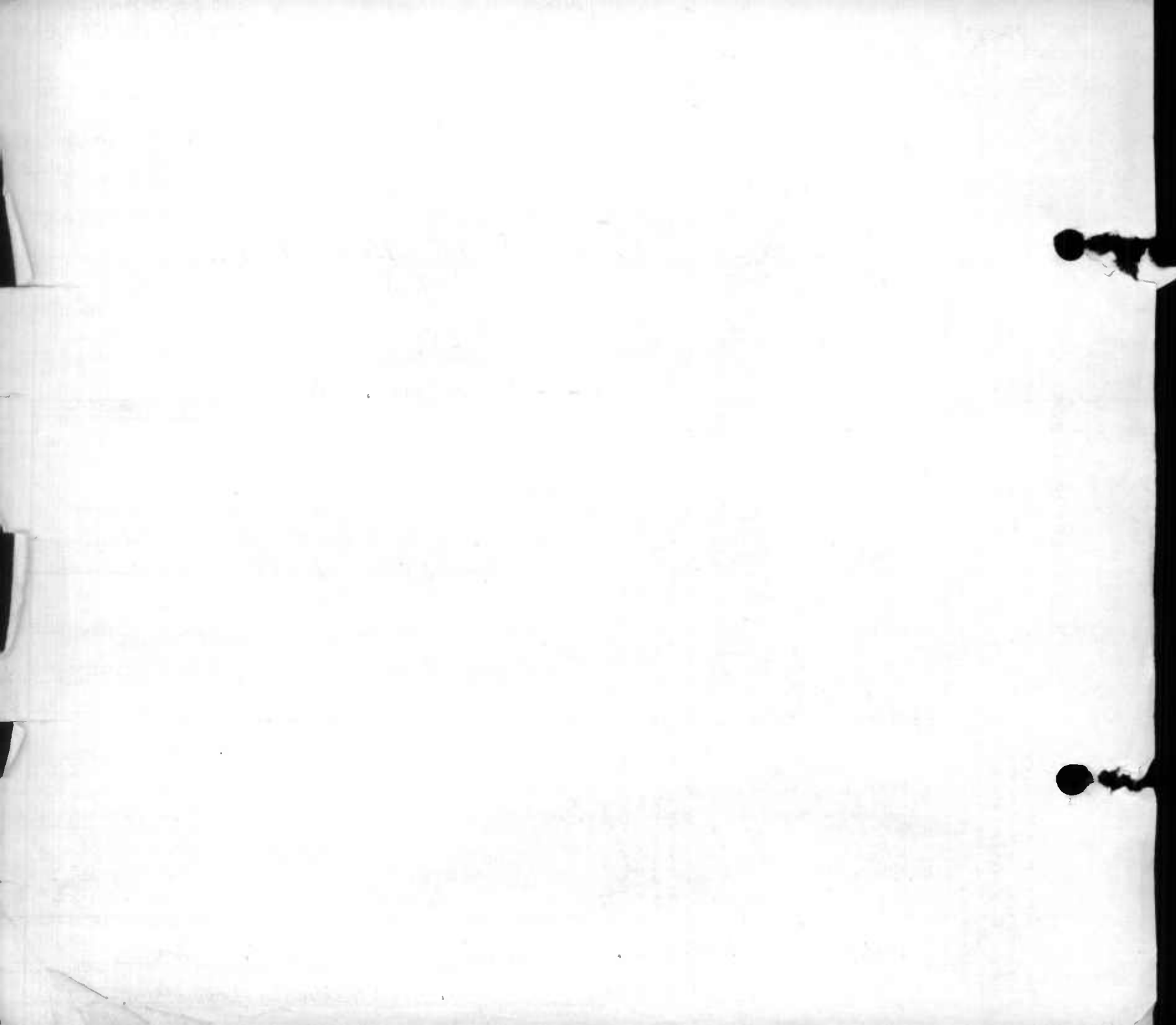
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-09221 65 6347				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 63474	
M.E. CASE NO.				BIRTH DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Ornella Savage				2. DATE AND HOUR OF DEATH March 28, 1965 3:50 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital Baltimore, Maryland				A. STATE Lombard Greene B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				D. STREET ADDRESS (If rural, give location) 2513 Loyola Southway 15-13			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single (Newborn)	8. DATE OF BIRTH 3/28/65	9. AGE (In years lost birthday) 0	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	57
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Vernon Albert Savage				14. MOTHER'S MAIDEN NAME Shirley Thompson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Mother		ADDRESS above
18. 75-731 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Atelectasis of lungs (B) life (C) life				INTERVAL BETWEEN ONSET AND DEATH life			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. life							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/28/65 to 3/28/65 , that (I) (we) last saw the deceased alive on 3/28/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Mitchell Solled						23B. DATE SIGNED 6/16/65	
23C. PHYSICIAN'S NAME (Type) Mitchell Solled		23D. ADDRESS Univ. Hosp. Balto Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) JUN 18 1965		24B. DATE		24C. NAME OF CEMETERY ANATOMY BOARD OF MARYLAND		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR SCHOOL MORTUARY SERVICE - BCHD		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

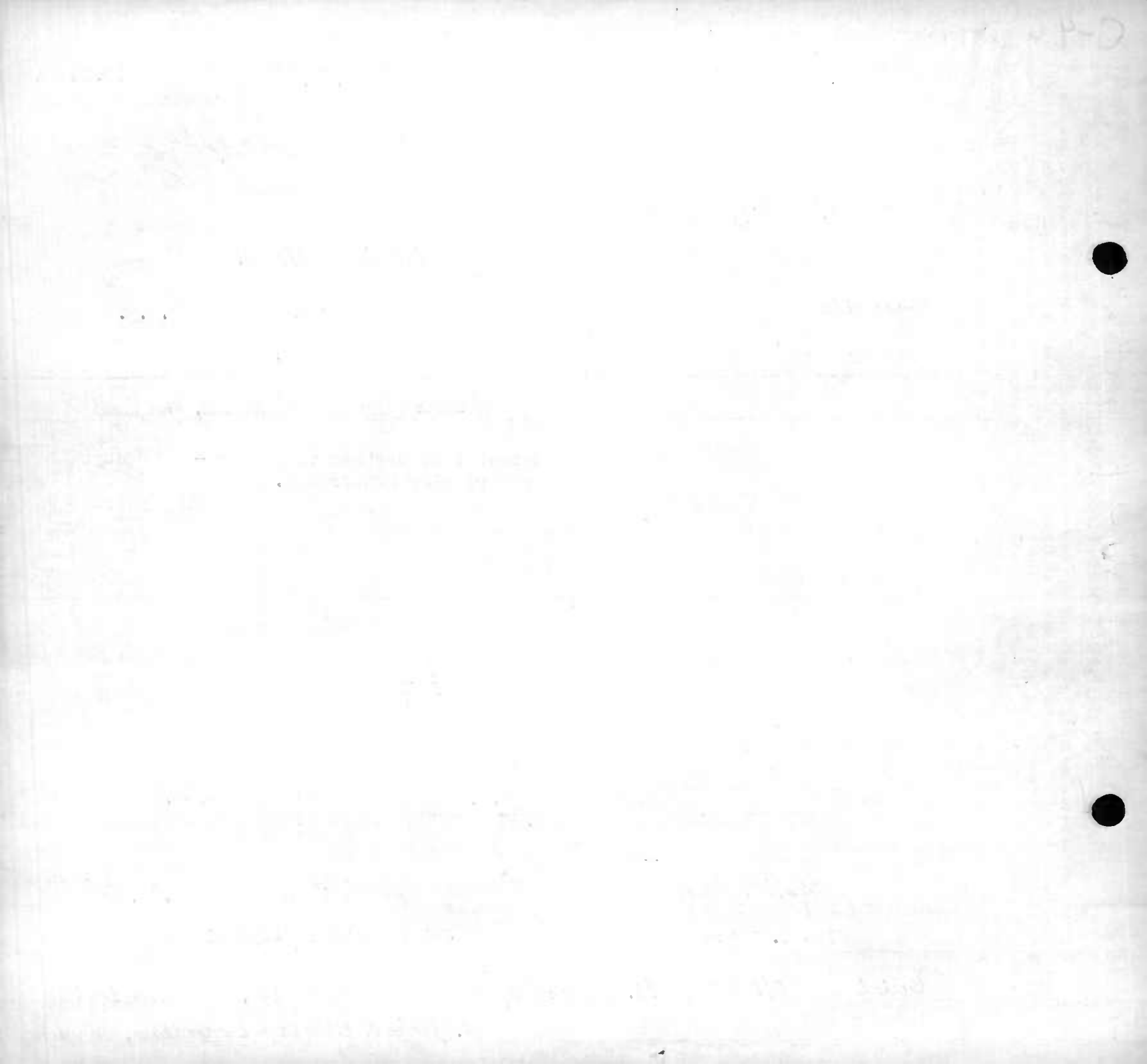
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6348	
BIRTH NO. 65 6348		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Cecilia Saunders</i>		2. DATE AND HOUR OF DEATH <i>6/15/65 4:00 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Balto</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hosp</i>		D. STREET ADDRESS (If rural, give location) <i>3120 St Paul ST</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>1/25/49</i>	9. AGE (In years, last birthday) <i>16/1/57</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John Rebel Garner</i>			14. MOTHER'S MAIDEN NAME <i>Agnes Ruth Payne</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>215-16-6545</i>		17. INFORMANT ADDRESS <i>Mrs Jane G. Gerhard</i>	
18. <i>260X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenic, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <i>Myocardial infarct</i> (B) DUE TO <i>dehydration, septicaemia, renal failure</i> (C) DUE TO <i>Urinary tract infect</i> <i>scabious, Mollusca</i>		INTERVAL BETWEEN ONSET AND DEATH <i>terminal</i> <i>Recent</i> <i>Recent</i> <i>years</i>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Not by medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>None</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/9/65</i> <i>1965</i> to <i>6/15</i> <i>1965</i> that (I) (we) last saw the deceased alive on <i>6/15</i> <i>1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (No) (did) (did not) view the body after death.					
23A. SIGNATURE <i>WE Schwartz</i>				23B. DATE SIGNED <i>6/15/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>WE Schwartz</i>		23D. ADDRESS <i>Mercy Hospital Balto</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/18/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Johns Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Hollywood Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 18 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR ADDRESS <i>W. Clarke Mattingley Leonardtown, Maryland</i>	



115 96 021
CLAY, EMMA
6-14-65
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FUNERAL DIRECTOR: IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6349		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6349	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Emma Clay		2. DATE AND HOUR OF DEATH 6/14/65 10:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) VALLEY LEE D. STREET ADDRESS (If rural, give location) 68-00			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5/12/24	9. AGE (In years lost birthday) 41	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME STEPHEN DYSON		14. MOTHER'S MAIDEN NAME AGNES CALVERY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Chester Clay Valley Lee, Maryland	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebral hemorrhage with intra-ventricular hemorrhage. HCV D (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 8 days years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/5/19 65 to 6/14/19 65, that (I) (we) last saw the deceased alive on 6/14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gino V. Segre		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/14/65	
23C. PHYSICIAN'S NAME (Type) Gino V. Segre		23D. ADDRESS M.D. Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/17/65		24C. NAME OF CEMETERY or CREMATORY St. George Cemetery	
24D. LOCATION (City, town, or county) (State) Valley Lee, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Maryland	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6350		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 6350	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) GRACE E. SCHREIBER			2. DATE AND HOUR OF DEATH JUNE 15, 1965 12:40 AM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 24A FENWAY		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 2-28-81	9. AGE (In years lost birthday) 84	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		10B. KIND OF BUSINESS OR INDUSTRY MEDICINE		11. BIRTHPLACE (State or foreign country) MD	12. CITIZEN OF WHAT COUNTRY? U.S
13. FATHER'S NAME EDGAR HEDGES			14. MOTHER'S MAIDEN NAME SARAH STINCHCOMB		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-18-9752A		17. INFORMANT HOSPITAL RECORDS	
18. 493X+12902.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. FRacture Rt. Hip.			CAUSE OF DEATH PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 5 DAYS
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? 24A Fenway	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 3 28 65 7:30 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? 24A Fenway fell out of chair	
22. I certify that (I) (this hospital) attended the deceased from 5-13 19 65 to 6-15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Irving L. Cooperstein				23B. DATE SIGNED JUNE 15, 1965	
23C. PHYSICIAN'S NAME (Type) Irving L. Cooperstein				23D. ADDRESS MONTEBELLO HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/17/65		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS Wm Cook-Brooks, Inc. 1217 St Paul St Baltimore, Md	

RELEASED BY: DR. R. BREITENECHER
FURNAL DIRECTOR: IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6351		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6351	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) PAUL F. BRUNK		2. DATE AND HOUR OF DEATH JUNE 8, 1965 5:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME + HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY AA C. CITY OR TOWN (If outside city limits, write RURAL and give township) PASADENA 21123 52-00 D. STREET ADDRESS (If rural, give location) 313 Clover Hill Road			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 1-6-15	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Allied Art Co.		10B. KIND OF BUSINESS OR INDUSTRY chauffer		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Paul E. Brunk		14. MOTHER'S MAIDEN NAME Anna BROWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 111111111		17. INFORMANT 216-03-2460 Dorothy Brunk - 305 Clover Hill Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death) DR. R. BREITENECHER FR. MEDICAL EXAMINERS OFFICE I RELEASED BY: CAUSE OF DEATH (A) atelectasis, lungs (B) Bilateral, extensive (C) Cancer of the Larynx		INTERVAL BETWEEN ONSET AND DEATH NOT A MEDICAL EXAMINER CHIEF OR ASST. MEDICAL EXAMINER			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6-8-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of Larynx		20A. AUTOPSY? (Yes or No) Yes -	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-6-65 19 to 6-8-65 19, that (I) (we) last saw the deceased alive on 6-8-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Manuel J. Tan		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-8-65	
23C. PHYSICIAN'S NAME (Type) MANUEL TAN		23D. ADDRESS Church Home + Hospital, Balto. 31, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 12/65		24C. NAME of CEMETERY or CREMATORY Meadowridge Mem. Park	
24D. LOCATION Howard County, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR R.V. Singleton, Glen Burnie, Md.			

Camp of the
distant
Cattle Creek Camp

March 9th

B-500

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 65 6352		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 6352	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) T. Earl Boone (Thadges)	
2. DATE AND HOUR PRONOUNCED DEAD June 13, 1965		8:00 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 15-04 1903 N. Smallwood Street	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 9/10/1928
9. AGE (In years last birthday) 36		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Librarian		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Nat Boone		14. MOTHER'S MAIDEN NAME Queen Wiggins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Alex Boone		ADDRESS 45 Lichenor St. Newark N.J.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John E. Adams, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED June 13, 1965			
23A. BURIAL CREMATION, REMOVAL (Specify) Removal		23B. DATE 6/16/65	
23C. NAME OF CEMETERY or CREMATORY Union Branch		23D. LOCATION (City, town, or county) (State) Caraforte N.C.	
24A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		24B. NAME OF REGISTRAR Robert E. Farley	
24C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 N. Meade St.	

WATKINS FORD

1714

9/10/1928

Spencer

1st Union

2nd Union

3rd Union

4th Union

5th Union

6th Union

7th Union

8th Union

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6353	
BIRTH NO. 65 6353			CERTIFICATE OF DEATH		
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Wyeola Carr			June 14, 1965 3:45 ^a PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217			A. STATE Maryland		
			B. COUNTY 14-62		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 1410 McCulloh Street		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 11-17-94	9. AGE (In years lost birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Barney Simpson <small>unknown</small>			14. MOTHER'S MAIDEN NAME Mary Barnett <small>unknown</small>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Edith Gray-daughter 2310 W. North Avenue 669-1876		
18. 570.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) kinked ileum with early infarction of small intestine (B) DUE TO (C) DUE TO			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 13, 19 65 to June 14, 19 65 , that (I) (we) last saw the deceased alive on June 14, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE M.Y. Ahmed			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 14, 1965
23C. PHYSICIAN'S NAME (Type) M.Y. Ahmed			23D. ADDRESS 1514 Division Street-Baltimore, Maryland		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/17/65	24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Howard St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6354	
BIRTH NO. 65 6354		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Sarah Smith		2. DATE AND HOUR OF DEATH June 15, 1965 7:45 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2404 Druid Hill Avenue Baltimore, Maryland 21217		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. STREET ADDRESS (If rural, give location) 2404 Druid Hill Avenue			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Oct. 18, 1894	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Exmore Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Harmon		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 225-18-7760		17. INFORMANT Roland Reid	
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made at dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Myocardial Insufficiency (B) DUE TO Hypertensive Cardiovascular Disease (C) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 years 6 years	
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 23, 1964 to June 15, 1965, that (I) (we) last saw the deceased alive on June 15, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Marcus W. Moore Sr		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 17, 1965	
23C. PHYSICIAN'S NAME (Type) Marcus W. Moore Sr		23D. ADDRESS 1371 N. Carey Street Baltimore Md.			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-19-65		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Arlington S. Phillips			
25D. ADDRESS 1727 Monroe Street					

Mr. J. C. ...
H. ...
D. ...
C. ...

June 12 1902
September 22 1902

Marion W. Moore Sr
Marion W. Moore Jr

1911 A. C. ...

BIRTH NO.

65 6355

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM WEATHERS

2. DATE AND HOUR PRONOUNCED DEAD

June 16, 1965

10:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

32 Wheeler Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5/19/1919

9. AGE (In years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Long Shaurman

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Fred Weathers

14. MOTHER'S MAIDEN NAME

Susanne Mc Bride

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

261-28-0918

17. INFORMANT

Annie Mae Weathers 3211. Wheeler Ave

ADDRESS

18. 023 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Luetic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-16-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/21/65

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Ph.

23D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 18 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Arlington S. Phillips 1727 N. Mount St

ADDRESS

2/19/1919
42
J. W. White
J. W. White
J. W. White
J. W. White

2/19/1919
J. W. White
J. W. White
J. W. White
J. W. White

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PAUL GLOVER, JR.

2. DATE AND HOUR PRONOUNCED DEAD

June 16, 1965

2:45 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

184 W. Hamburg St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

10-12-1944

9. AGE (in years
last birthday)

18

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Steel Mill

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Paul Glover

14. MOTHER'S MAIDEN NAME

Eva German

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 322.01

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Acute ethylism
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-17-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-19-1965

23C. NAME OF CEMETERY or CREMATORY

Arbutus Mem Park

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 18 1965

24B. NAME OF REGISTRAR

Robert E. Farkas, M.D.

24C. FUNERAL DIRECTOR

Isaiah L. Brown & Son

ADDRESS

WALLLEY FORDGE

W. WALLLEY FORDGE

W. WALLLEY FORDGE

W. WALLLEY FORDGE

W. WALLLEY FORDGE

W. WALLLEY FORDGE

W. WALLLEY FORDGE

W. WALLLEY FORDGE

W. WALLLEY FORDGE

W. WALLLEY FORDGE

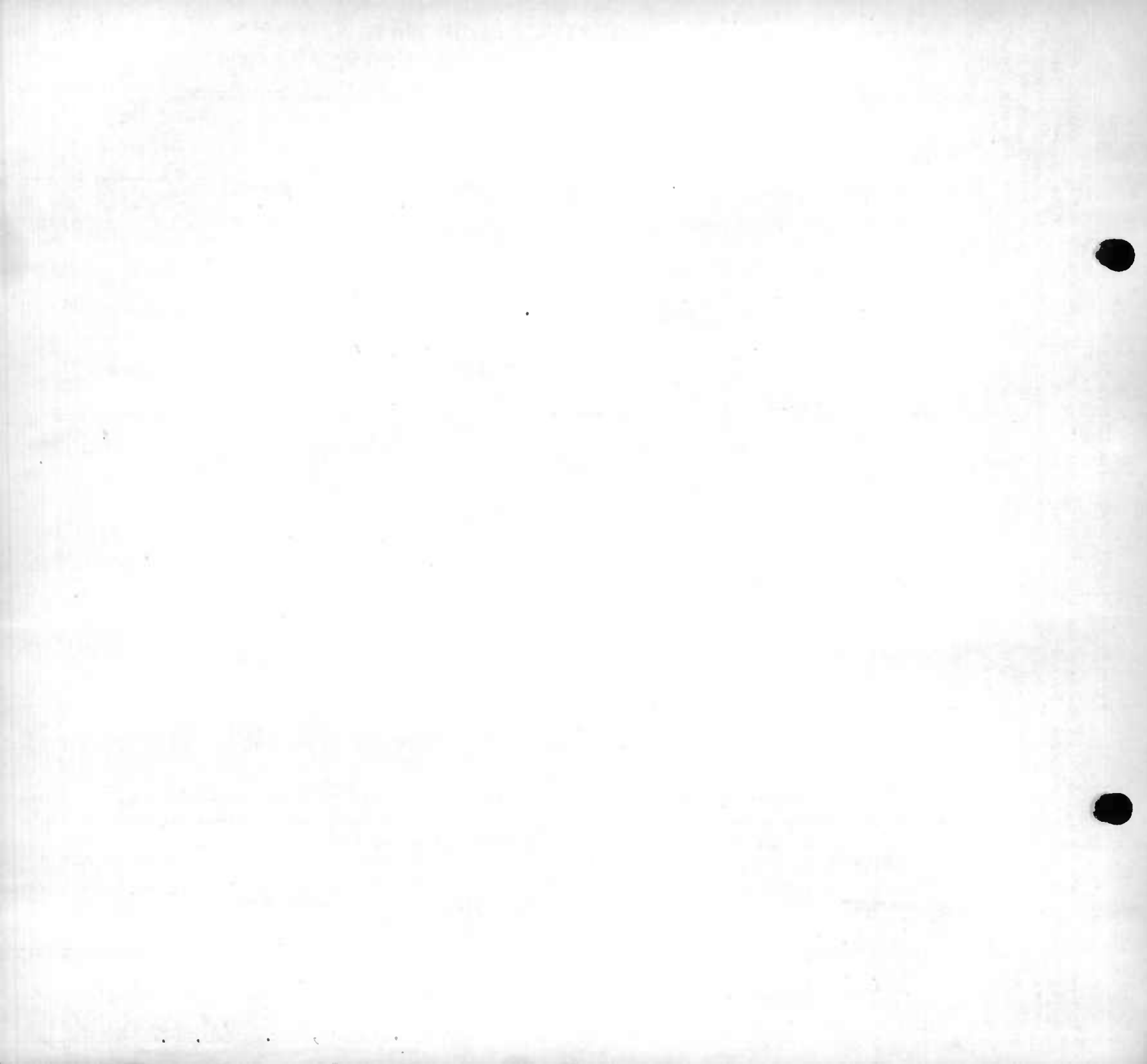
W. WALLLEY FORDGE

W. WALLLEY FORDGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 6357		CERTIFICATE OF DEATH		65 6357	
1. NAME OF DECEASED (Type or Print) John J. Little			2. DATE AND HOUR OF DEATH June 17, 1965 10:45A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY Balto city		
5. SEX m			6. RACE cau		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Caulker		10B. KIND OF BUSINESS OR INDUSTRY City Water Dept.		11. BIRTHPLACE (State or foreign country) Md	
13. FATHER'S NAME Nicholas Little			14. MOTHER'S MAIDEN NAME Alice - O'Dea		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Acc Rm Sheet	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) hypotension 2° to dehydration and bilobar pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. myocardial infarction hypothyroidism.			INTERVAL BETWEEN ONSET AND DEATH ?		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-15 1965 to 6-17 1965, that (I) (we) last saw the deceased alive on 6-17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph H. Marr				23B. DATE SIGNED 6-17-65	
23C. PHYSICIAN'S NAME (Type) J. Joseph Marr		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/21/65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION Baltimore		24E. LOCATION (City, town, or county) Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Fagan		25C. FUNERAL DIRECTOR John A. Moran, Inc. Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6358	
BIRTH NO. 65 6358		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Joseph Mincsik</i>		2. DATE AND HOUR OF DEATH <i>June 17 1965 7⁰⁰ A M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i>		A. STATE <i>Md</i> B. COUNTY <i>6-01</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
		D. STREET ADDRESS (If rural, give location) <i>5 N. Decker Avenue</i>			
5. SEX <i>M.</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>12/25/107</i>	9. AGE (In years last birthday) <i>57</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lithographing</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Printing</i>		11. BIRTHPLACE (State or foreign country) <i>Johnstown, Pa.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Joseph Mincsik</i>		14. MOTHER'S MAIDEN NAME <i>Hobor, Martha.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT ADDRESS <i>Mrs Anna Mincsik 5. N. Decker Ave.</i>	
18. <i>163X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <i>Carcinoma of the Lung</i> DUE TO (B) <i>Metastasis to the vertebrae</i> (C) <i>scapula rib.</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/26</i> 19 <i>65</i> to <i>6/17</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>7⁰⁰ AM 6/17</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Kyungsho M. Cynn</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/17/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Kyungsho M. Cynn</i>		M.D. <i>Md</i>		23D. ADDRESS <i>General Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/21/65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 18 1965</i>		25B. NAME OF REGISTRAR <i>John A. Moran, Inc.</i>	
25C. FUNERAL DIRECTOR ADDRESS <i>3000 E. Balto. St.</i>					

James M. Hester
Superintendent
No. 10

John A. Hester
Theodore A. Hester
Hester Bros.

Consolidation of the fund
to be made as soon as possible
25th May 1902

What is the
total amount?

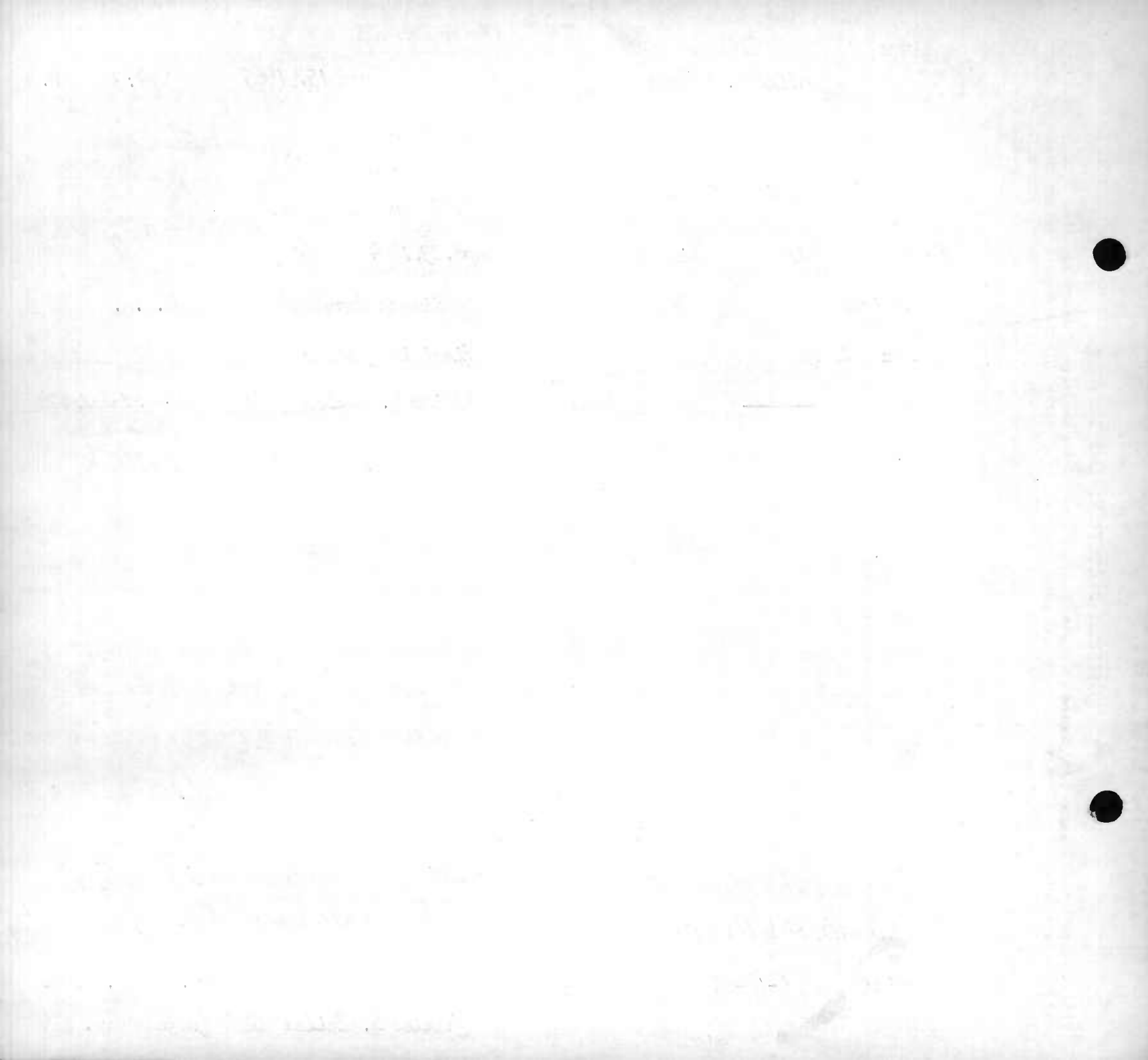
Mr. General Hospital
No. 10

James M. Hester
Superintendent

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6359				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6359			
M.E. CASE NO.								CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Alice R. Hohman</i>						2. DATE AND HOUR OF DEATH <i>June 15, 1965</i> <i>4:30</i> P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital) or institution, give street address or location						A. STATE <i>Maryland</i> B. COUNTY <i>26-09</i>					
<i>408 Elrino Street #24</i>						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #24</i>					
						D. STREET ADDRESS (If rural, give location) <i>7403 Mueller Street</i>					
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>Sept. 23, 1884</i>		9. AGE (In years last birthday) <i>80</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>House Work</i>				11. BIRTHPLACE (State or foreign country) <i>Baltimore Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Alec Wiley</i>						14. MOTHER'S MAIDEN NAME <i>Virginia Cooksey</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>William J. Forbes</i>				ADDRESS <i>408 Elrino Street #24</i>	
18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>ARTERIOSCLEROTIC C.U.D.S.</i>						CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						INTERVAL BETWEEN ONSET AND DEATH <i>10/15</i>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6/12</i> 19 <i>65</i> to <i>6/15</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>6/11</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Benjamin Hylton</i>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6/16/65</i>			
23C. PHYSICIAN'S NAME (Type) <i>DR. B. HILTON</i>						23D. ADDRESS <i>M. J. HILTON RD. BALTO. MD.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>6-18-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>				24D. LOCATION (City, town, or county) (State) <i>7225 Eastern Blvd. Balto. 24, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 18 1965</i>				25B. NAME OF REGISTRAR <i>Robert E. Farley</i>				25C. FUNERAL DIRECTOR ADDRESS <i>Charles S. Zeiler 6224 Eastern Ave. #24</i>			



W-300

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 6360

BIRTH NO. 5

65 6360

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DORETTA I. WHITE

2. DATE AND HOUR OF DEATH

6-17-65 12:35 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Mercy Hosp. P.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND 20-07

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTO

D. STREET ADDRESS (If rural, give location)

3915 Edmondson Ave

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

11-13-99

9. AGE (In years
lost birthday)

65

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

H.W.

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Frederick Morrison

14. MOTHER'S MAIDEN NAME

Bertha Jeffrey

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

213 28 1063 James R. White, 1127 Newfield Rd

17. INFORMANT

ADDRESS

18. 334x1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) Hypertensive Encephalopathy
DUE TO(B) Hypertension
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

16-16-65

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Hypertensive Encephalopathy

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐ Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~IN~~ (this hospital) attended the deceased from 6-11-1965 to 6-17-1965.
that ~~I~~ (we) last saw the deceased alive on 6-17-1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Salvatore R. Donohue

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6-17-65

23C. PHYSICIAN'S
NAME (Type)

Salvatore R. Donohue M.D.

23D. ADDRESS

Mercy Hosp.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/19/65

24C. NAME of CEMETERY or CREMATORY

New Cathedral

24D. LOCATION

Balto. 29, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 18 1965 Robert E. Fisher

25B. NAME OF REGISTRAR

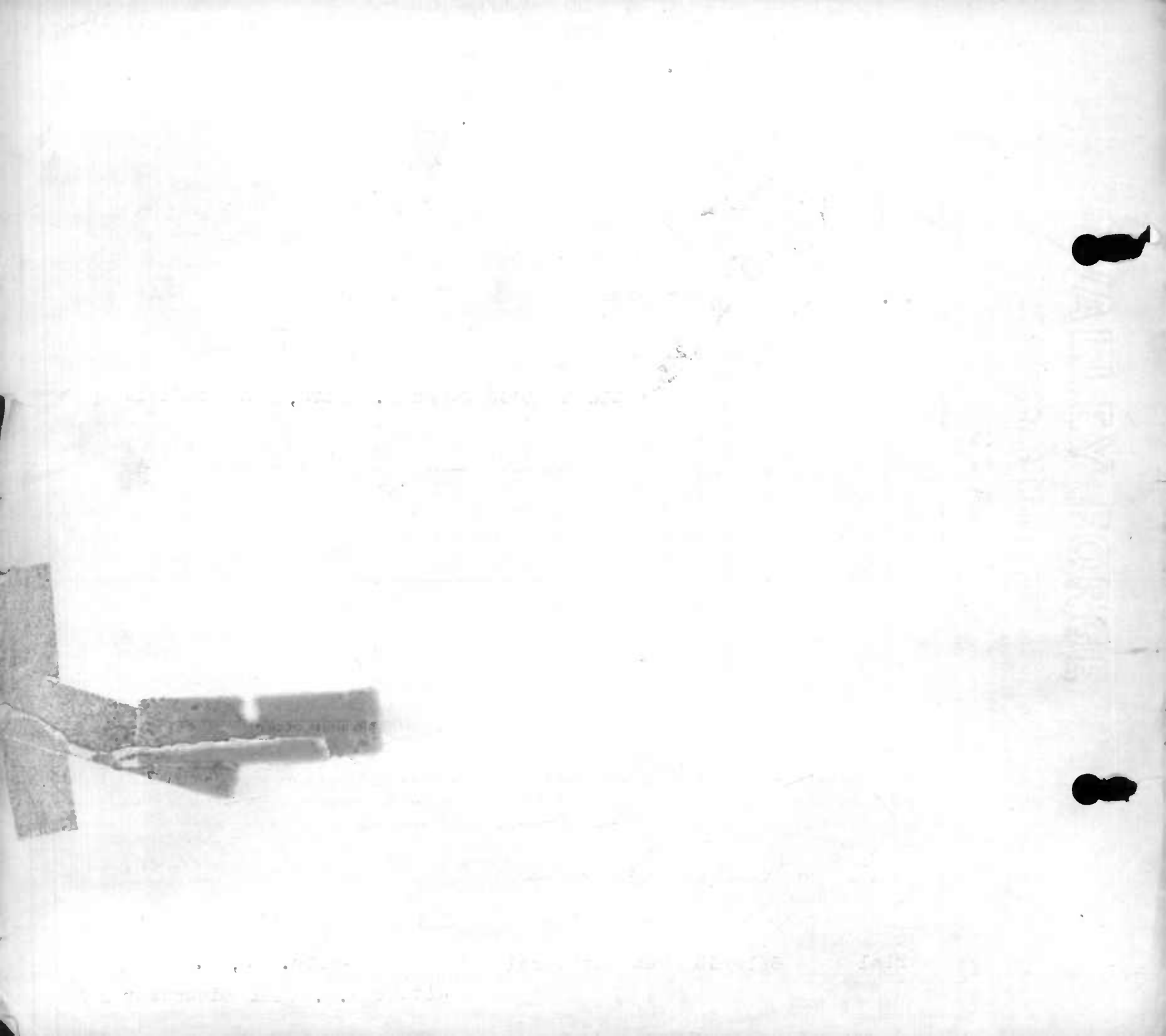
25C. FUNERAL DIRECTOR

Witzke F.D. 4101 Edmondson Ave

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

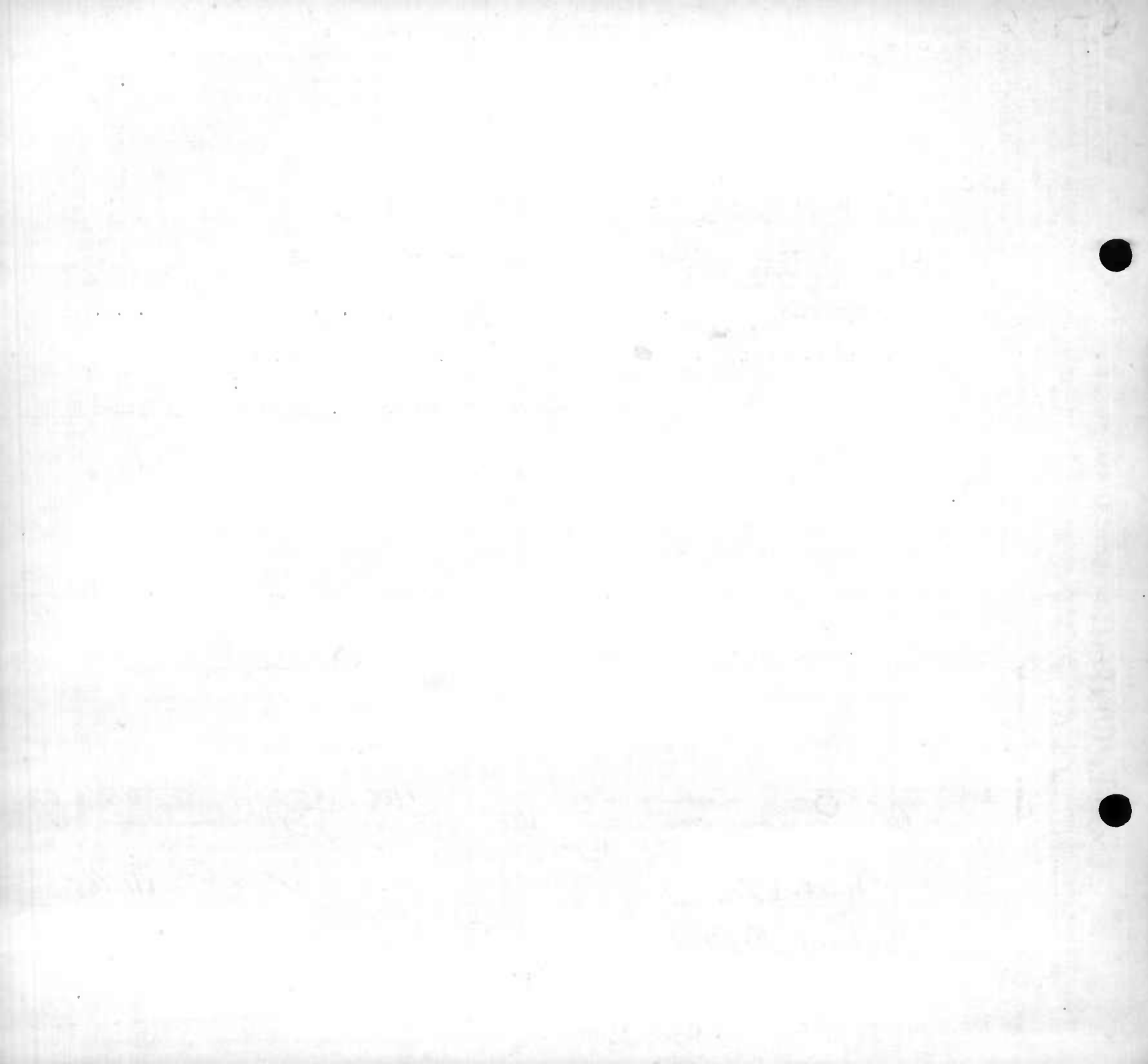
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

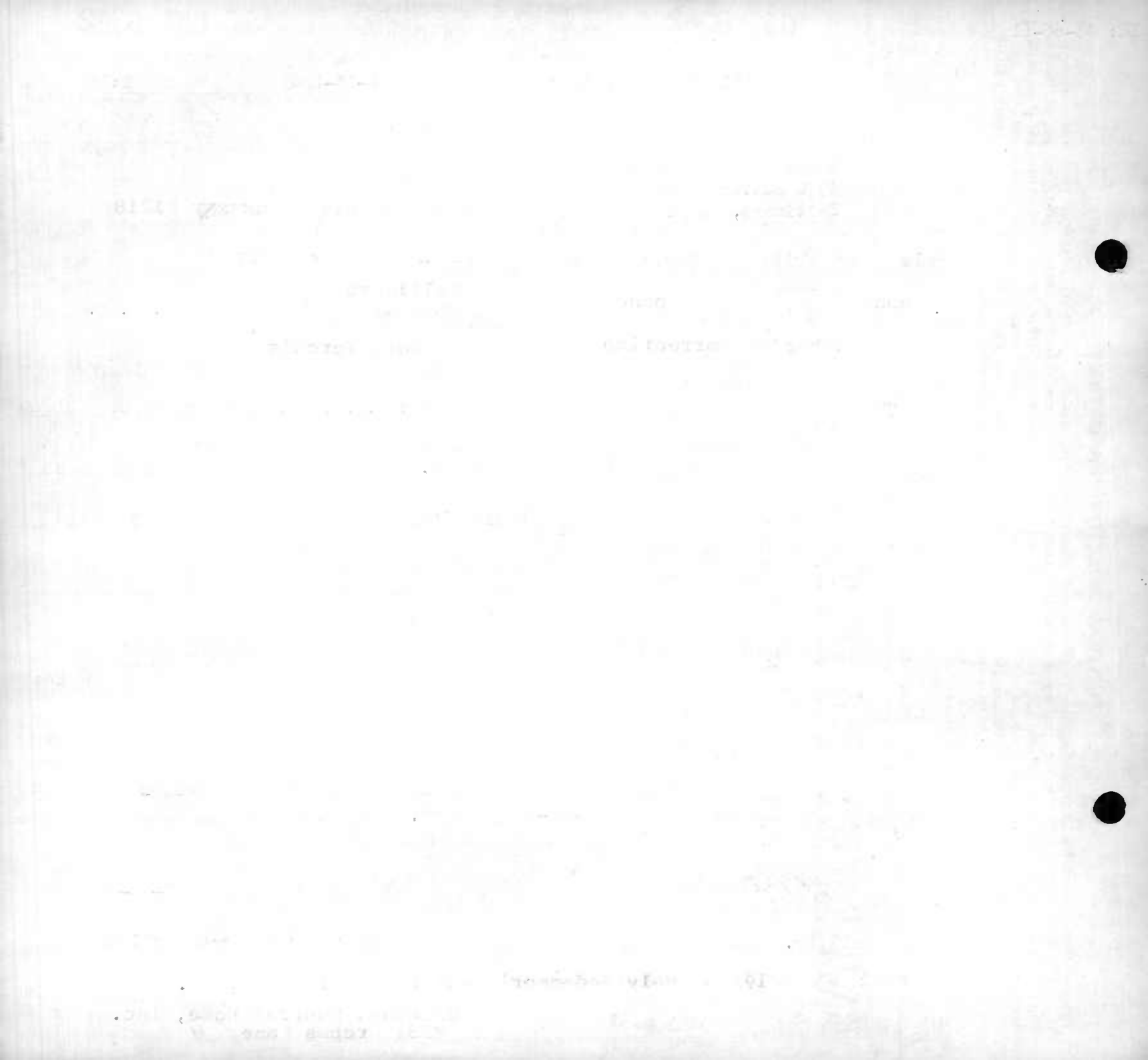
BIRTH NO. 65 6361		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6361	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ALPHONSE OLDEWURTEL		2. DATE AND HOUR OF DEATH 6-15-65 5:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 D. STREET ADDRESS (If rural, give location) 103 BLADEN ROAD #21			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12-31-21	9. AGE (In years last birthday) 43	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Body Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HENRY OLDEWURTEL		14. MOTHER'S MAIDEN NAME KATHERINE BANKERT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-12-0649		17. INFORMANT Mrs Margaret M. Oldewurtel 103 Bladen R	
18. 493X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) PNEUMONIA (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6/14 19 65 to 6/15 19 65, that (1) (we) lost saw the deceased alive on 6/15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael Freund		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/15/65	
23C. PHYSICIAN'S NAME (Type) Michael Freund		23D. ADDRESS M.D. 550 N. Broadway			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6-18-1965	24C. NAME of CEMETERY or CREMATORY Belair Memorial Cemetery		24D. LOCATION Belair Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Lassahn Funeral Home 7461 Belair Road	
25D. ADDRESS (36)					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6362	
BIRTH NO. 65 6362		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William Sorrentino		2. DATE AND HOUR OF DEATH 6-16-1965 1:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		A. STATE Maryland B. COUNTY 9-08			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 2201 Aiken Street #21202 21218			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 8-26-1917	9. AGE (In years last birthday) 47	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Baltimore Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Charles Sorrentino		14. MOTHER'S MAIDEN NAME Rose Torchia	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: B.C.H. 4940 Eastern Avenue #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Gastro Intestinal Hemorrhage with (A) Aspiration. DUE TO (B) Peptic Ulcer DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 10 Minutes 3 weeks			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-22-19 65 to 6-16-19 65 , that (I) (we) last saw the deceased alive on 6-16-19 65 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-16-65	
23C. PHYSICIAN'S NAME (Type) Dr. Howard Rathbun		23D. ADDRESS 4940 Eastern Avenue #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/19/65		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
		24D. LOCATION Baltimore, Md.		(State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	
				ADDRESS	



65 6363

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Wallace Jackson

2. DATE AND HOUR OF DEATH

June 14, 1965

4:15-P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

RURAL:

D. STREET ADDRESS (If rural, give location)

2436 Lodge Farm Road #21219

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

8-6-05

9. AGE (In years
lost birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

STEEL MILL

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

213-09-0866

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #21224

18.

331X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

(A) Cerebrovascular Accident

10 Minutes

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 3, 19 65 to June 14, 19 65
that (I) (we) last saw the deceased alive on June 14, 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

D. C. C. J. Carpenter

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

June 14, 19 65

23C. PHYSICIAN'S
NAME (Type)

Dr. C. C. J. Carpenter

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland #24

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6-18-65

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem.

24D. LOCATION

A.A. Co

(City, town, or county)

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

JUN 18 1965

25B. NAME OF REGISTRAR

Robert E. Fairbank

25C. FUNERAL DIRECTOR

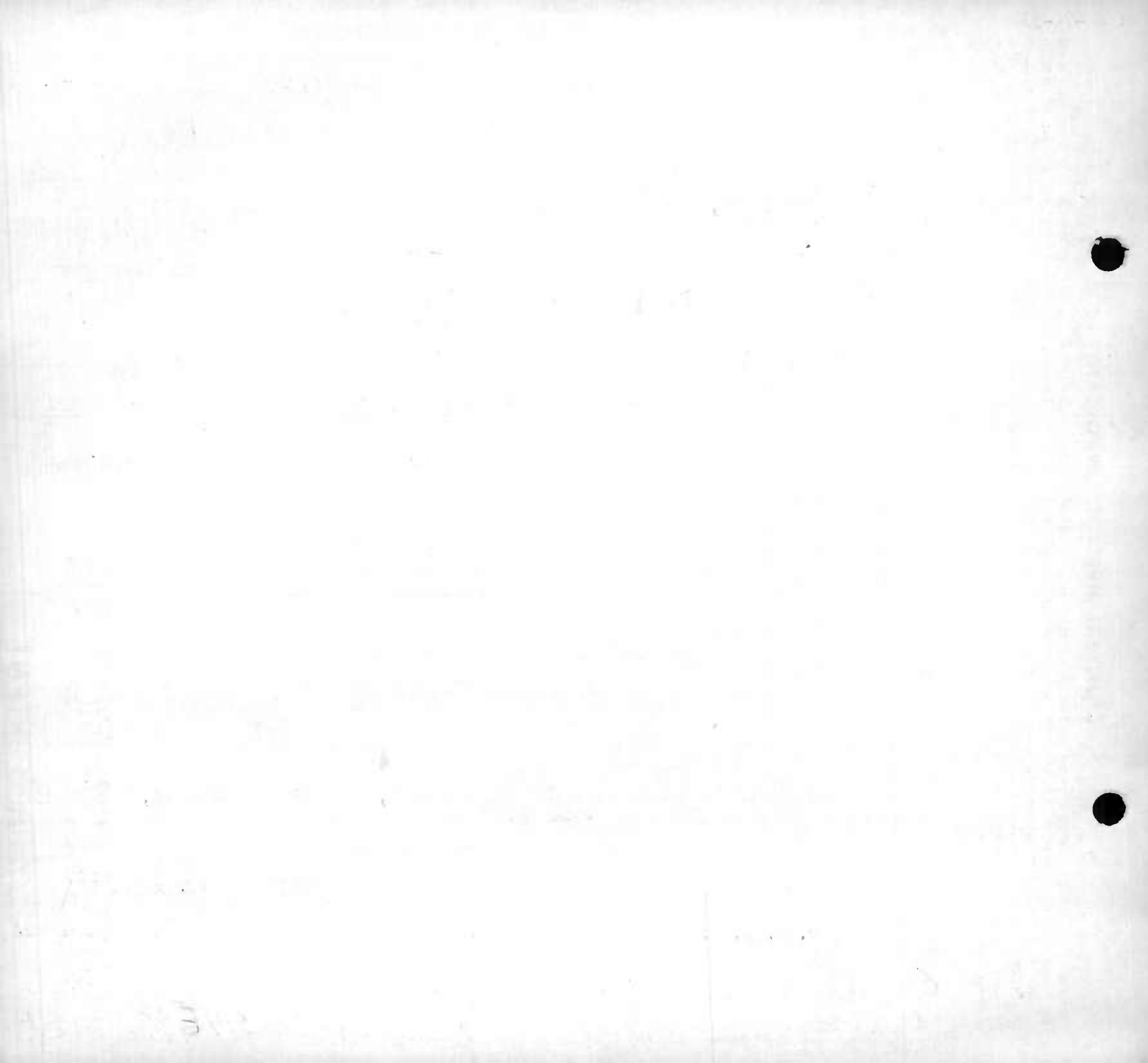
Rayner Sanders

ADDRESS

217 E Preston St

FUNERAL DIRECTOR: IMPORTANT

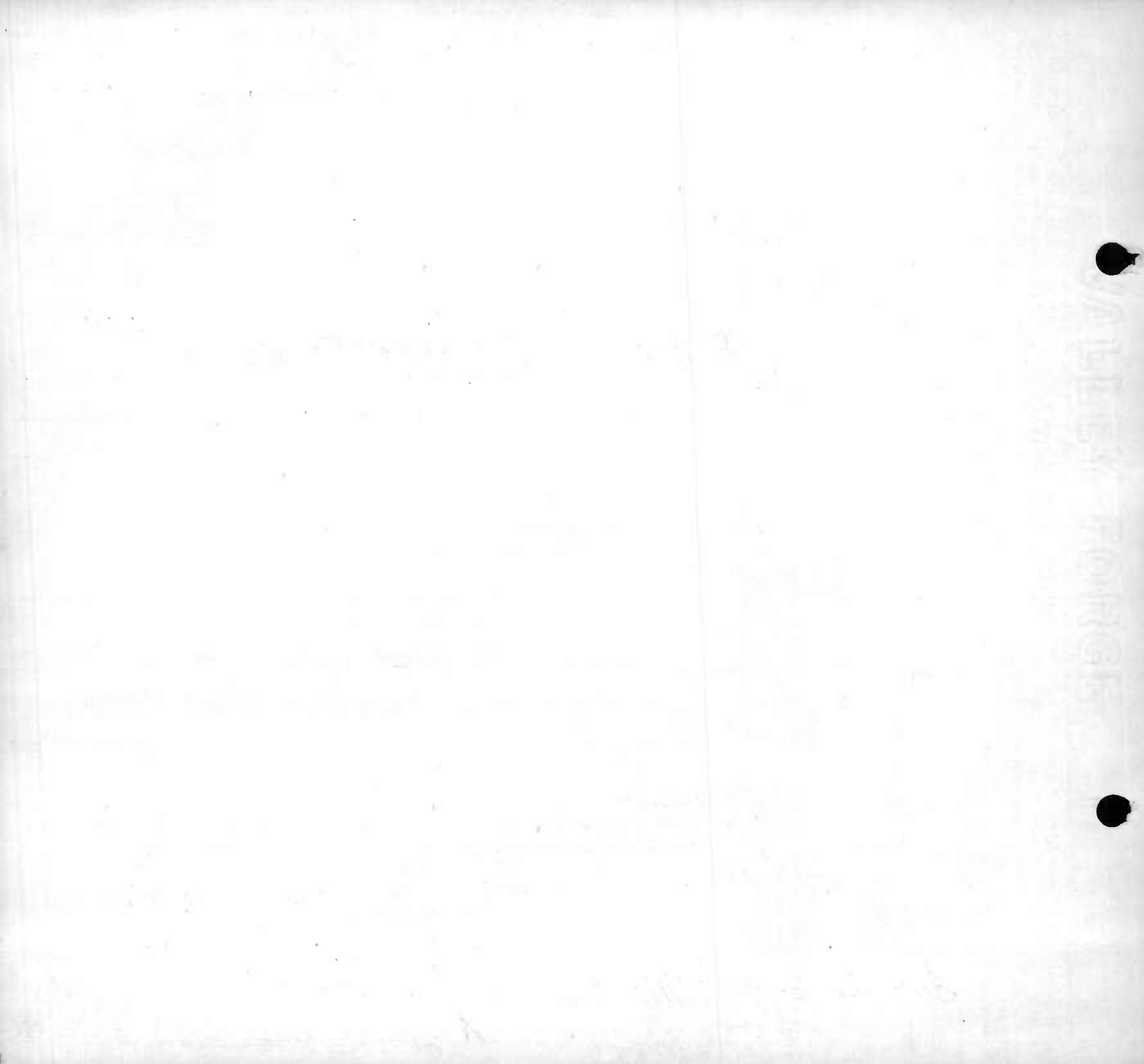
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6364				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6364	
1. NAME OF DECEASED (Type or Print) Annie Lawrence				2. DATE AND HOUR OF DEATH June 15, 1965 11:50p M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1519 Argyle Avenue			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH June 1, 1880	9. AGE (In years lost birthday) 85	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Neal unknown			14. MOTHER'S MAIDEN NAME Charolette Chambers unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hilda White-daughter		ADDRESS same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cardiovascular accident, thrombosis DUE TO (B) Cerebral arterio-atherosclerosis DUE TO (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 9, 19 65 to June 15, 19 65 , that (I) (we) last saw the deceased alive on June 15, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. Blackmon				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 15, 1965	
23C. PHYSICIAN'S NAME (Type) R. Blackmon				23D. ADDRESS M.D. 1514 Division St. - Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-19-65		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem Balto		24D. LOCATION (City, town, or county) (State) Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Paynor Sanders ADDRESS 217 E Preston St			



C-452

BALTIMORE CITY HEALTH DEPARTMENT				65 6365	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
BIRTH NO. 65 6365					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD			
CHARLES COLLINS		June 16, 1965 11:08 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 41 St. Josephs Hospital		A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-01 D. STREET ADDRESS (If rural, give location) 1047 Harford Avenue			
5. SEX male	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH March 9 1944	9. AGE (in years last birthday) 21	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sumter S.C.	
13. FATHER'S NAME Eugene Collins		14. MOTHER'S MAIDEN NAME Julia Hardy Holland		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Julia Collins - 1047 Harford Ave.	
18. CAUSE OF DEATH 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breiteneker		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6-17-65	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE June 21/65		23C. NAME of CEMETERY or CREMATORY Mt Calvary Cems.	
24A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR Milton E. Elickson 1129 McCarroll St	
24D. LOCATION (City, town, or county) (State) A.A. County Md					

PAGE SEVENTEEN

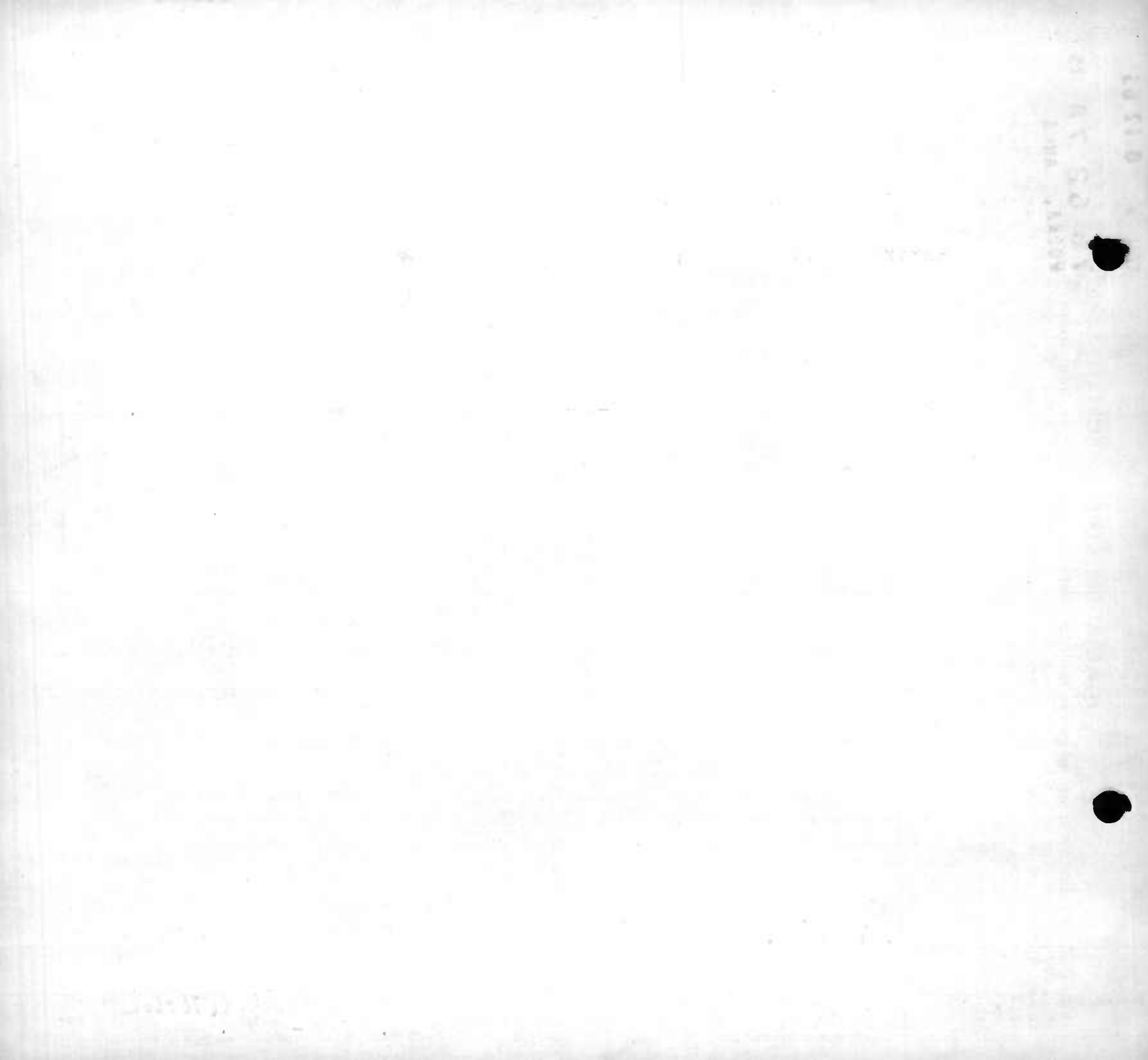
WALTER B. BROWN

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ANNA WODKA		6/17/65 11:05		11:05 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
33 JOHNS HOPKINS HOSPITAL			MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 2106 FLEET STREET		
5. SEX FEMALE XXXX	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1-19-93	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? Poland		13. FATHER'S NAME ? Klimek		14. MOTHER'S MAIDEN NAME Anna ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-14-4809		17. INFORMANT Chester Wodka - 2106 Fleet Street. #31	
18. 292.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Probable recurrent pneumonia (B) DUE TO Agnoq. myeloid metaplasia (C) _____		INTERVAL BETWEEN ONSET AND DEATH 1 week 6 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. n/o bleeding ulcers					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/16 19 65 to 6/17 19 65, that (II) (we) last saw the deceased alive on 6/17 19 65 and that in (III) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Willis C. Maddrey				23B. DATE SIGNED 6/17/65	
23C. PHYSICIAN'S NAME (Type) DR. WILLIS C. MADDREY		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/21/65		24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR George A. Weber - 705 S. Ann Street #31	



FUNERAL DIRECTOR: IMPORTANT

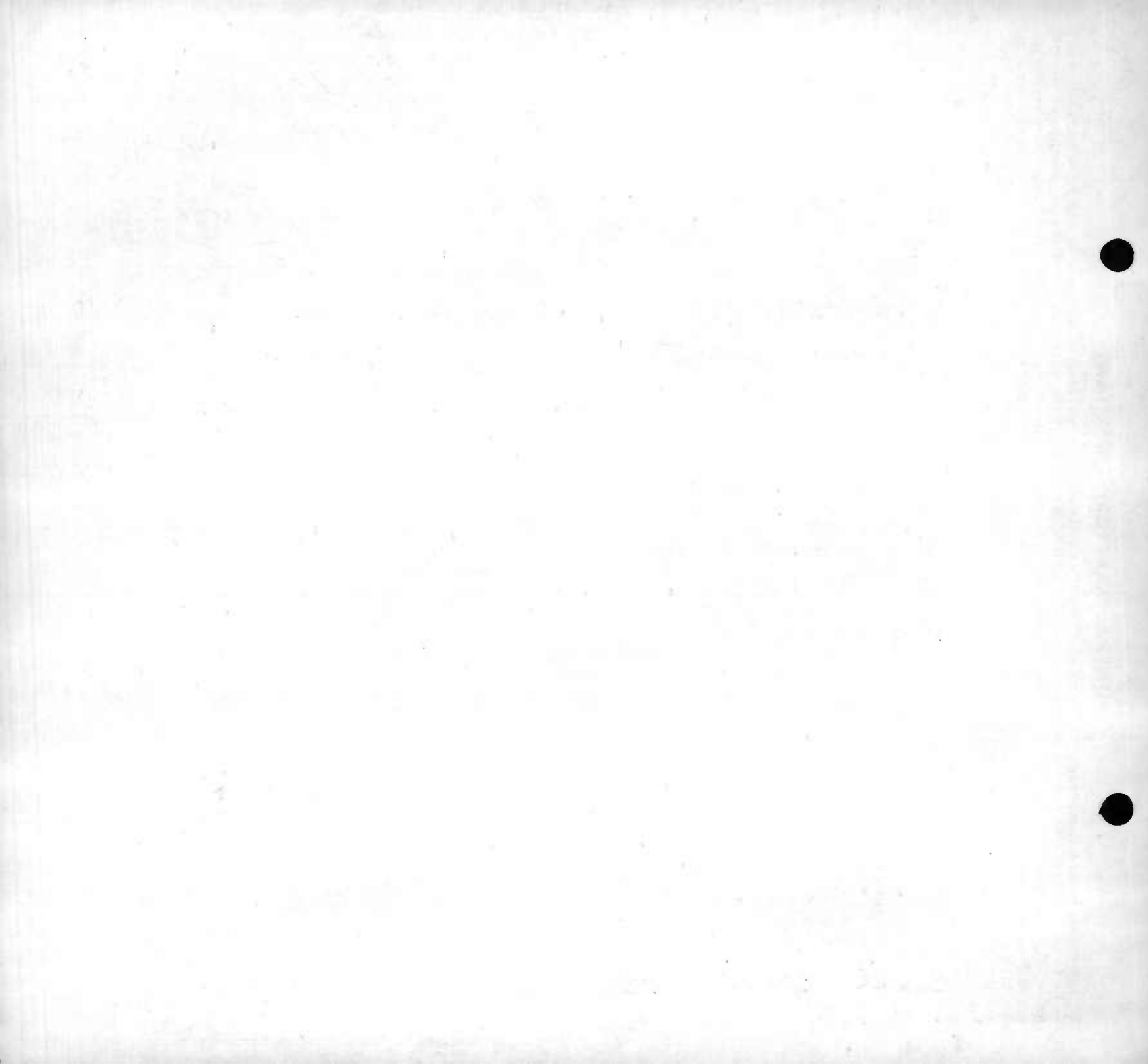
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6367				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6367	
1. NAME OF DECEASED (Type or Print) ROSETTA WOODS				2. DATE AND HOUR OF DEATH 6-17-65 1:00 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND				A. STATE MARYLAND B. COUNTY 15-05			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				D. STREET ADDRESS (If rural, give location) 3000 KEISTERSTOWN RD.			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH	9. AGE (In years last birthday) 65	10. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Anna Grindel, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lloyd Woods				14. MOTHER'S MAIDEN NAME Rosetta Waters			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 219-32-0178		17. INFORMANT ADDRESS Lion Queen 2536 Salem St.	
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ACUTE PULMONARY EDEMA				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIO SCLEROTIC CARDIO- VASCULAR DISEASE							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-17-65 to 6-17-65 , that (I) (we) last saw the deceased alive on 6-17-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
22A. SIGNATURE Jesus G. Santiano M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		22B. DATE SIGNED 6-17-65	
23A. PHYSICIAN'S NAME (Type) JESUS G. SANTIANO				23D. ADDRESS LUTHERAN HOSPITAL OF MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal June 17/64		24B. DATE June 17/64		24C. NAME of CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Isom		25C. FUNERAL DIRECTOR U. Brooks Ruggold		ADDRESS 14637 Cary St	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

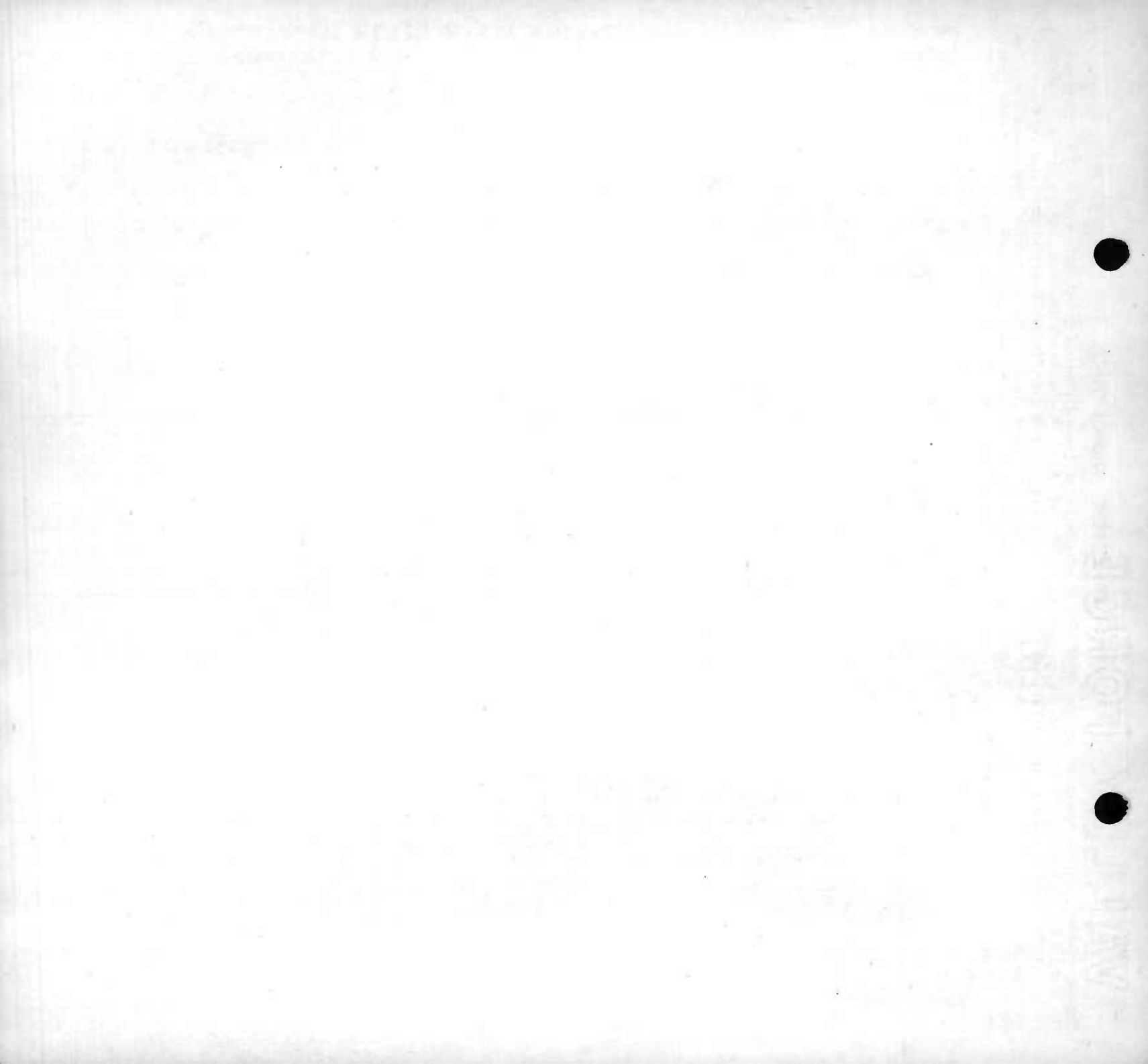
BIRTH NO. 65 6368				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6368	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) LEE CORA S.			
2. DATE AND HOUR OF DEATH 6/11/65 8:38 P.M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND LUTHERAN HOSPITAL OF MD.			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-38				5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MD.			
6. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				7. STREET ADDRESS (If rural, give location) 2405 ROSLYN AVE.			
8. SEX F		9. RACE C		10. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		11. DATE OF BIRTH 75.	
12. AGE (in years lost birthday) 75.		13. If Under 1 Yr. Months: Days: Hours: Min.		14. If Under 24 Hrs. Min.		15. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED				17. KIND OF BUSINESS OR INDUSTRY			
18. FATHER'S NAME James H. Smith				19. MOTHER'S MAIDEN NAME unknown			
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.				21. SOCIAL SECURITY NO.			
22. INFORMANT Miss Obee 2418 Preston St				23. ADDRESS			
24. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) C.V.D. INTERVAL BETWEEN ONSET AND DEATH 6 days.				25. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				27. MEDICAL CERTIFICATION			
28. DATE OF OPERATION 6/11/65		29. CONDITION FOR WHICH OPERATION WAS PERFORMED		30. AUTOPSY? (Yes or No)		31. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
32. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		33. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		34. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		35. HOW DID INJURY OCCUR?	
36. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		37. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		38. I certify that (I) (this hospital) attended the deceased from 6/5 19 65 to 6/11 19 65 , that (I) (we) last saw the deceased alive on 6/11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		39. SIGNATURE Joan Sueck LEE M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
40. PHYSICIAN'S NAME (Type) JOAN SUECK LEE		41. ADDRESS LUTHERAN HOSPITAL OF MD.		42. DATE SIGNED 6/11/65		43. BIRTHAL CREMATION, REMOVAL (Specify) Burial	
44. DATE 6/16/65		45. NAME OF CEMETERY or CREMATORY Mt Airy Cemetery		46. LOCATION (City, town, or county) (State) Balto Md		47. DATE REC'D BY HEALTH DEPT. JUN 18 1965	
48. NAME OF REGISTRAR Robert E. Farley		49. FUNERAL DIRECTOR Ed Wilson		50. ADDRESS		51. VS 150-REV. 1/1/65	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 6369		CERTIFICATE OF DEATH		65 6369	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Jennifer S. Waters.		6-15-1965 About 2 ⁰⁰ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Home - 2814 Rayner Ave.		Maryland 16-06			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		2814 Rayner Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	B. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days
M	C	W		72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Laborer		None	Cambridge, Md	U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Joseph Waters		Unknown			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No					
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) Hypertensive Arteriosclerotic		6+ weeks	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		C.V.D.			
II		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6-7-65 19 to 6-15-19 65, that (I) (we) last saw the deceased alive on 6-7-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Lucius W. Keeper				June 17, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Lucius W. Keeper		1200 Bloomingdale Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	6-19-65	Mt. Calvary Cmn.		Brooklyn Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 18 1965		Robert E. Farkley		C. S. Wilson 1000 Brandy Ave.	



FUNERAL DIRECTOR: IMPORTANT

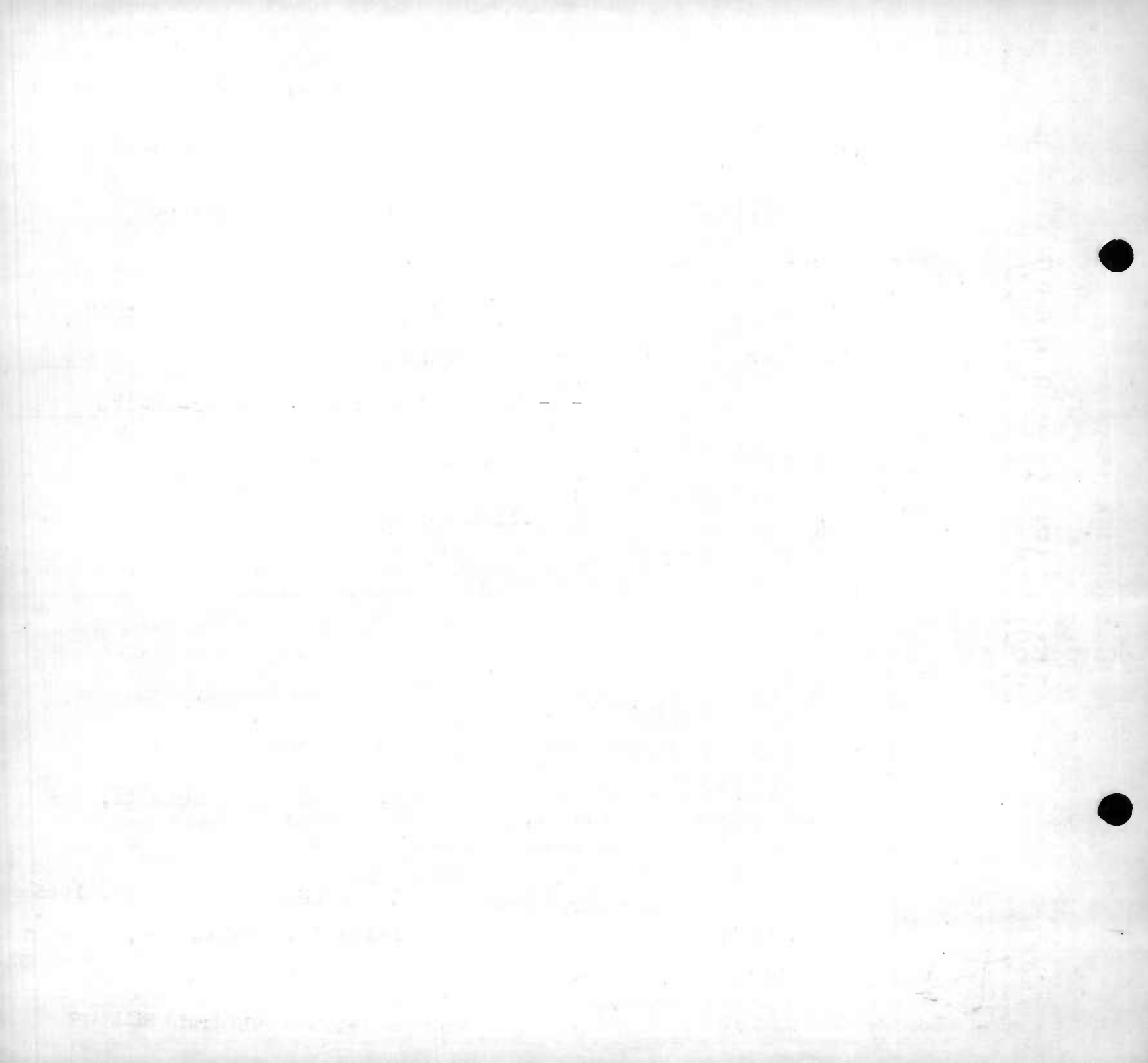
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 6370

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Catherine Jones		June 11, 1965 6:20am	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Provident Hospital				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				2353 Druid Hill Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
Female	Negro	widowed	July 29, 1897	67			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
none		none		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
unknown				unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		215-01-4352		Catherine Jones daughter-in-law		same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
				(A) Cerebro-vascular accident DUE TO			
				(B) G.I. Bleeding DUE TO			
				(C)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 8, 1965 to June 11, 1965, that (I) (we) last saw the deceased alive on June 11, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. Theodore						23B. DATE SIGNED June 12, 1965	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS	
R. Theodore						1514 Division St. Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/17/65		Mt Calvary Cemetery		A A County Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 18 1965		Robert E. Farley		Adolphus Halstead		918 Druid Hill Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

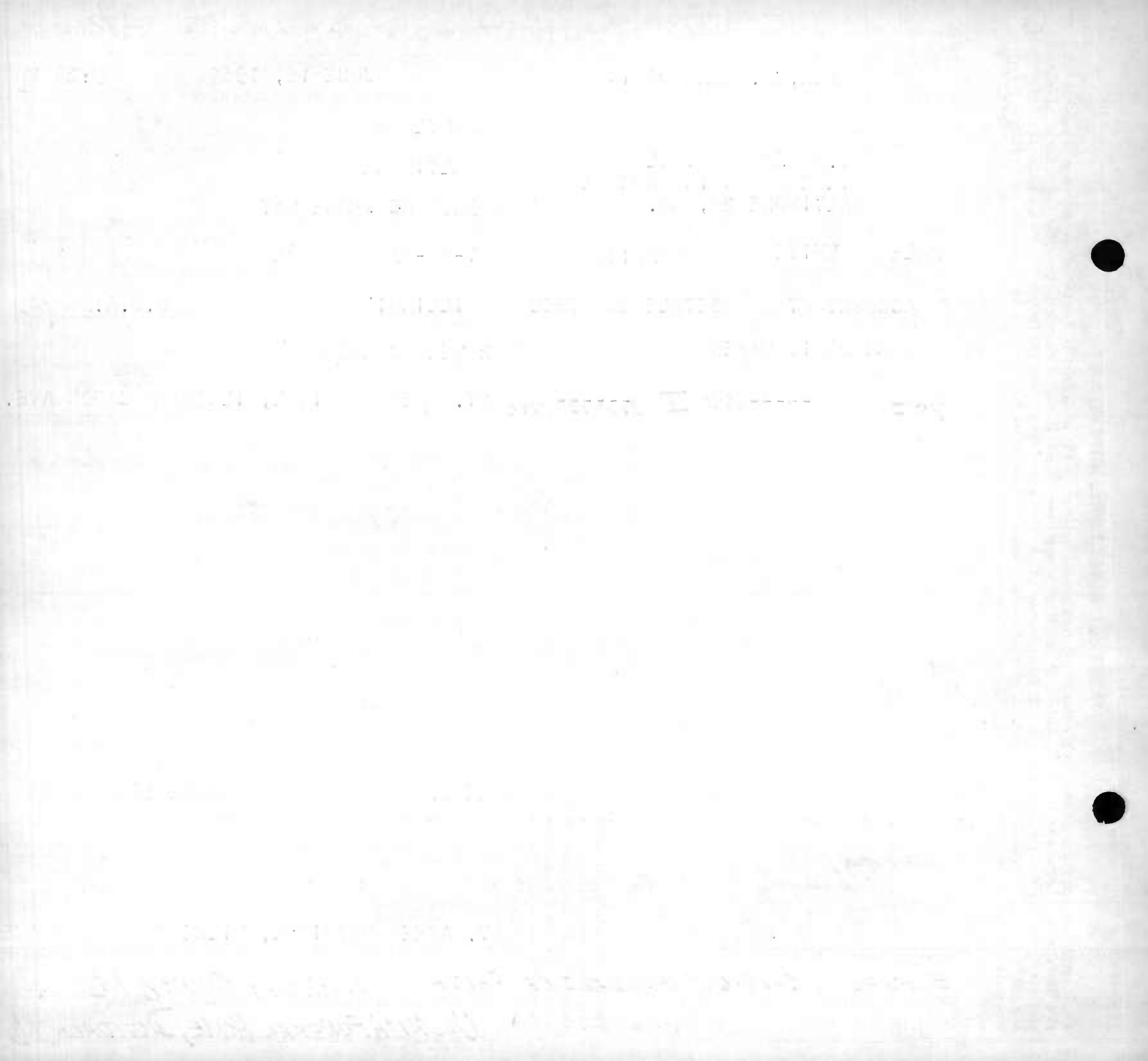
BIRTH NO. 65 6371		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6371	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Clarence Robinson</u>		2. DATE AND HOUR OF DEATH <u>June 17, 1965</u> <u>5:30 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>26-36</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>		D. STREET ADDRESS (If rural, give location) <u>6513 CLEVELAND AVENUE</u>			
5. SEX <u>WHITE</u>	6. RACE <u>MALE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>5-12-89</u>	9. AGE (In years lost birthday) <u>76</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
13. FATHER'S NAME <u>ROSS ROBINSON</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH HORTMAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-07-5784</u>		17. INFORMANT <u>Mrs. Clara Robinson</u> ADDRESS <u>6513 Cleveland Ave.</u>	
18. <u>578X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <u>Cardiac Insufficiency</u> DUE TO <u>Myocardial Infarct, Congestive Heart Failure</u> (B) <u>GI Bleeding</u> DUE TO (C) <u>GI Bleeding</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u> <u>10 days</u> <u>2 weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NO</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 5</u> 19 <u>65</u> to <u>June 17</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>June 17</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>D. Edwards Smith</u> M.D.				23B. DATE SIGNED <u>June 17, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>D. EDWARDS SMITH</u>		23D. ADDRESS <u>Johns Hopkins</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/18/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Pleasant Hill Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Moggantown, W. Va.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 18 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairley</u>		25C. FUNERAL DIRECTOR <u>Ullrich Funeral Home Dundalk, Md.</u>	

CO 12
23 00

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

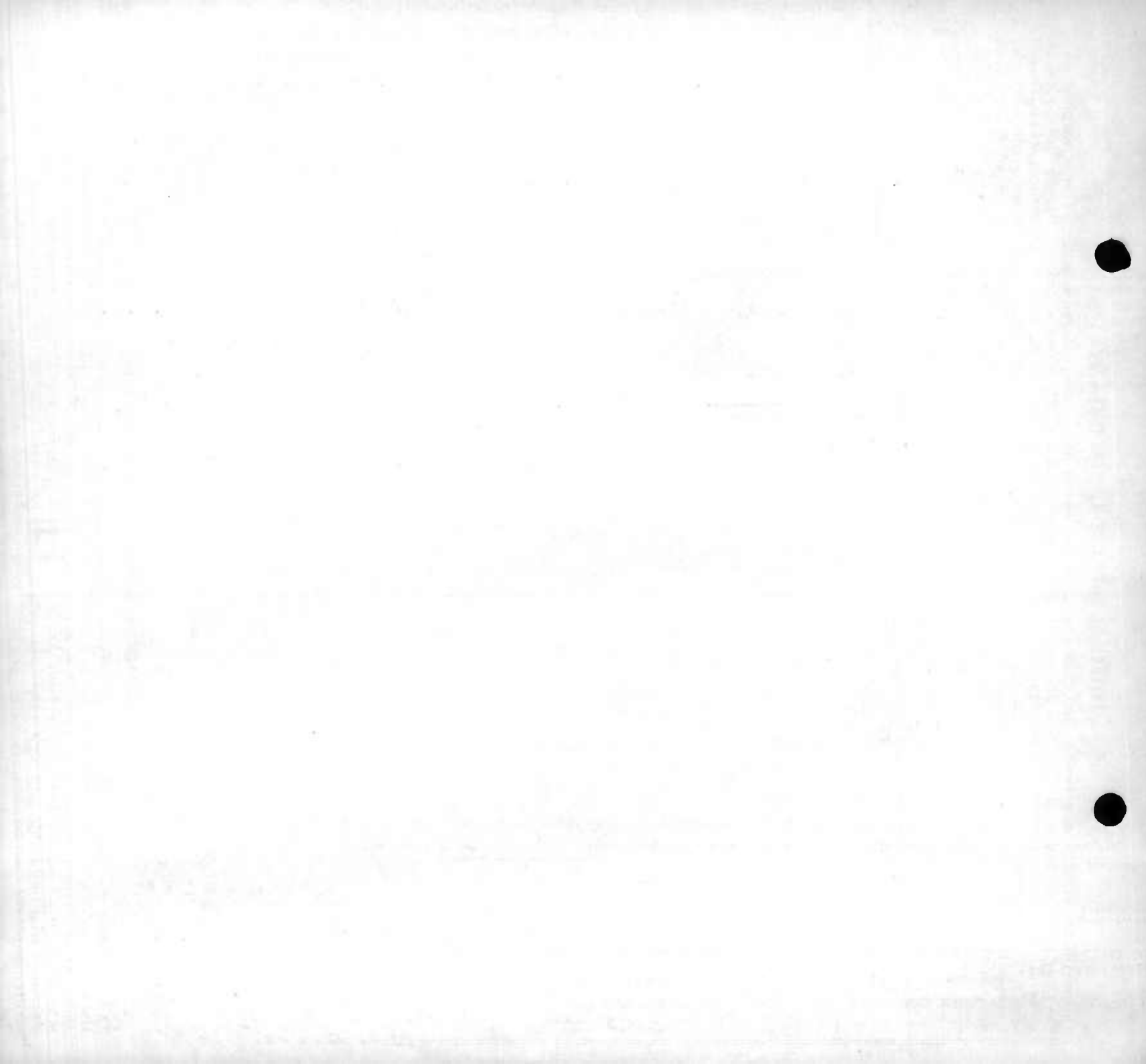
BIRTH NO. 65 6372		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6372	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WAFER, SR. JOHN DAVID		2. DATE AND HOUR OF DEATH JUNE 16, 1965 9:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 29, MD.		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY Balt C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3318 MC SHANE WAY			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-21-23	9. AGE (In years lost birthday) 42	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		10B. KIND OF BUSINESS OR INDUSTRY BETHEHEM STEEL		11. BIRTHPLACE (State or foreign country) ILLINOIS	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN DAVID WAFER		14. MOTHER'S MAIDEN NAME ROWENA JOHNSON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 512-76-5166		17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
18. 330X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) SUB ARACHNOID HEMORRHAGE. 2 days ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PROB. BERRY ANEURYSM		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 16 19 65 to JUNE 16 19 65 , that (I) (we) last saw the deceased alive on JUNE 16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Ulrich</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-17-65	
23C. PHYSICIAN'S NAME (Type) Ulrich		23D. ADDRESS M.D. ST. AGNES HOSPITAL, WILKENS & CATON AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-19-65		24C. NAME of CEMETERY or CREMATORY GARDENS OF FAITH	
24D. LOCATION (City, town, or county) (State) BALTIMORE COUNTY, MD.		25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS ULRICH FUNERAL HOME, DUNDALK, MD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6373				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6373	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Vincent J. Polomski				2. DATE AND HOUR OF DEATH 6-17-65 4 ¹⁰ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 24-01	
South Baltimore General Hospital				C. CITY OR TOWN Baltimore		(If outside city limits, write RURAL and give township)	
				D. STREET ADDRESS (If rural, give location) 1622 E Clement ST			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4/9/17	9. AGE (In years last birthday) 48	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10B. KIND OF BUSINESS OR INDUSTRY Central Police Station Elevator Operator		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hypolite Polomski				14. MOTHER'S MAIDEN NAME Pauline Niedjelski			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-20-2773		17. INFORMANT 202 Willow Lane S W Edward Polomski Glen Burnie, Md.			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Coronary Insufficiency 9mo DUE TO (B) Acute Myocardial Infarction 2 days DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None							
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/15/65 19 to 6/17/65 19, that (I) (we) last saw the deceased alive on 6/17/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John M. Ratino M.D.				23B. DATE SIGNED 6/17/65		23C. PHYSICIAN'S NAME (Type) John M. RATINO M.D.	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/21/65		24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave.			



BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 6374 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 6374

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES HAMMOND

2. DATE AND HOUR PRONOUNCED DEAD

June 16, 1965

10:05 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

938 W. Saratoga Street

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LONGSHOREMAN PORT BALTO.

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

James H. Hammond

14. MOTHER'S MAIDEN NAME

Edith Meads

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

215-26-4497

17. INFORMANT

Edith Hammond

ADDRESS

18. 381.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty cirrhosis of the liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
(If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-17-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/18/65

23C. NAME of CEMETERY or CREMATORY

Mt Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

JUN 18 1965

24B. NAME OF REGISTRAR

Robert E. Fadden

24C. FUNERAL DIRECTOR

Marshall P. Rogers 638 W. Guilford St

ADDRESS

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE ASSISTANT SECRETARY FOR CEREALS AND GRAIN

WASHINGTON, D. C.

January 1, 1918

Dear Sir:

I have the honor to acknowledge the receipt of your letter of December 18, 1917, in relation to the matter of the

grain inspection service, and in reply to inform you that the same has been forwarded to the

proper authorities for their consideration.

I am, Sir, very respectfully,

Yours very truly,

W. H. HARRIS

Assistant Secretary for Cereals and Grain

Enclosed for you are two copies of a report of the

grain inspection service, which you may find of interest.

I am, Sir, very respectfully,

Yours very truly,

W. H. HARRIS

Assistant Secretary for Cereals and Grain

Enclosed for you are two copies of a report of the

grain inspection service, which you may find of interest.

I am, Sir, very respectfully,

Yours very truly,

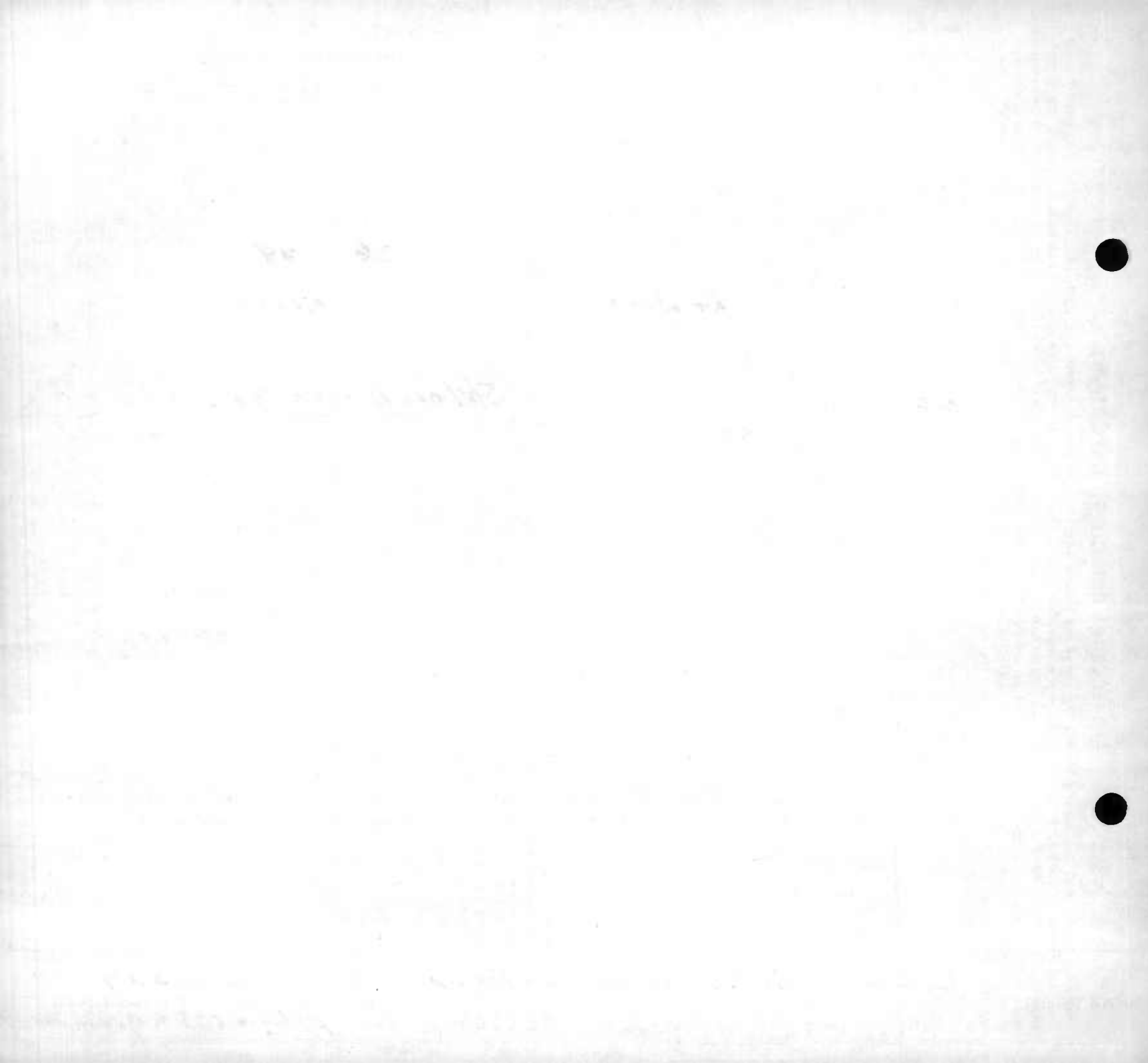
W. H. HARRIS

Assistant Secretary for Cereals and Grain

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6375				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6375	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) RUBY BUTLER L.				2. DATE AND HOUR OF DEATH June 17, 1965 3:30 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOUR HOSP. FAYETTE BALT. 23, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 20-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 19 N. Wheel Ave #23			
5. SEX F	6. RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-9-26	9. AGE (In years last birthday) 38	II Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) GEORGIA - MACON		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ELIJAH PASCO				14. MOTHER'S MAIDEN NAME SUSIE M. WOLFORD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT STILLMAN BUTLER 19 N WHEELER AVE		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 390X1+260X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Oliguria Pneumonia DIABETES MELLITUS (yr)				CAUSE OF DEATH (A) Subarachnoid Hemorrhage DUE TO Box of brain, left (B) RUPTURED ANEURYSM DUE TO 2 days (C) HYPERTENSION years		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 15 1965 to June 17 1965 , that (I) (we) last saw the deceased alive on June 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Frank C. Palad				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 17, 1965	
23C. PHYSICIAN'S NAME (Type) FRANK C. PALAD		23D. ADDRESS Medicines Hosp. 71P St. Balt 23 Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/18/65		24C. NAME OF CEMETERY OR CREMATORY Cheltenham Park		24D. LOCATION (City, town, or county) (State) Baltimore 21227	
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Man... 63829...		ADDRESS	



1
W-525

65 6376 BALTIMORE CITY HEALTH DEPARTMENT 65 6376

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **FREDERICK J. WANKMILLER**

2. DATE AND HOUR PRONOUNCED DEAD
June 15, 1965 1:15 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
243 S. Broadway

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **243 S. Broadway**

5. SEX **male** 6. RACE **white** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **NEVER MARRIED**

8. DATE OF BIRTH **4-10-1898** 9. AGE (In years last birthday) **67** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **GUARD** 10B. KIND OF BUSINESS OR INDUSTRY **TEXTILE CO.** 11. BIRTHPLACE (State or foreign country) **MARYLAND** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **JOHN F. WANKMILLER** 14. MOTHER'S MAIDEN NAME **EMMA WILL**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. **216-18-9152** 17. INFORMANT **Mrs. Estelle D. Langley - 2416 Mc Elderry St.** ADDRESS

18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **4-22-1** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **CAUSE OF DEATH** 20A. AUTOPSY? (Yes or No) **No** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

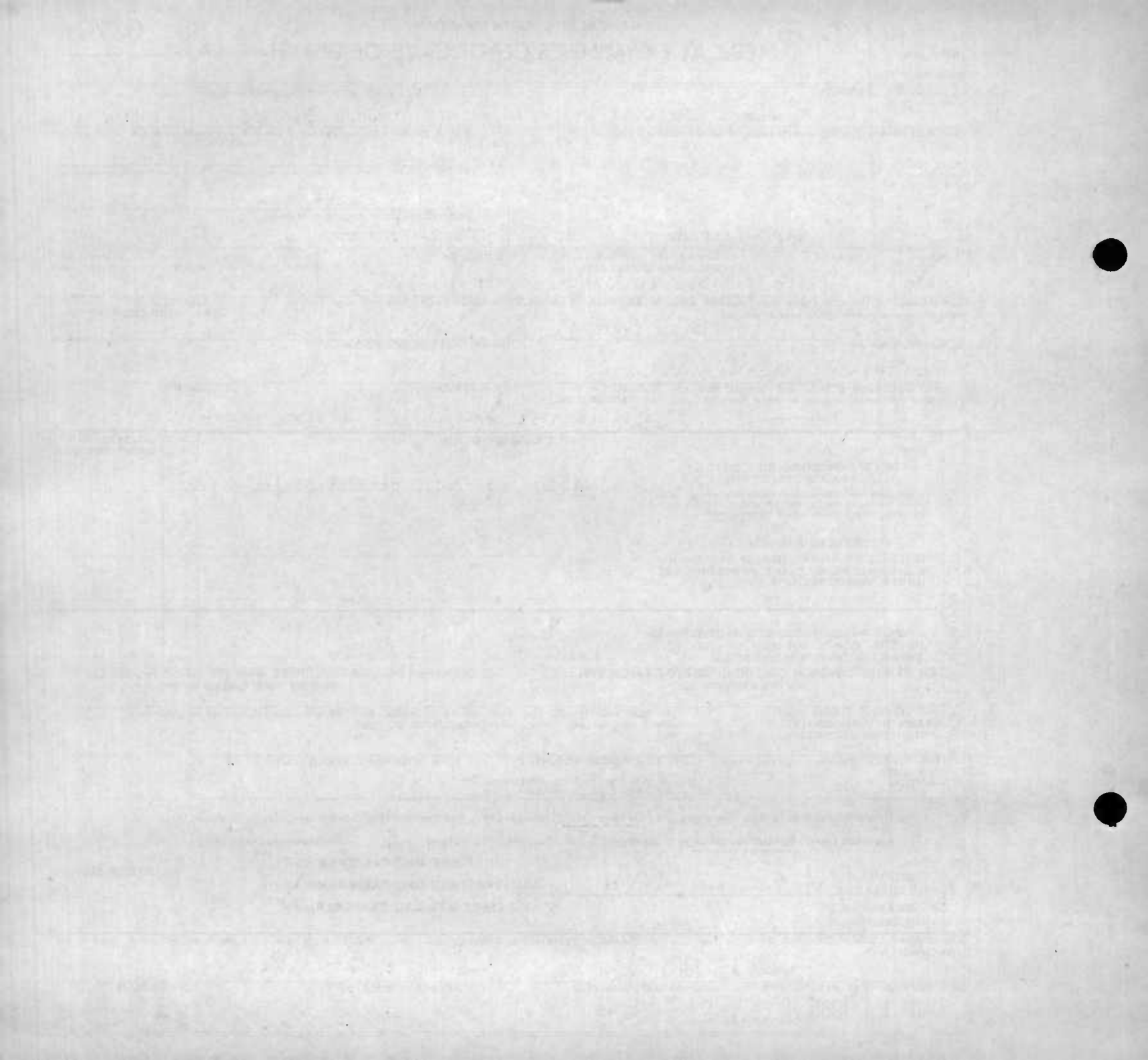
22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **John E. Adams** M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED **6-15-65**

EXAMINER'S NAME (Type) **John E. Adams**

23A. BURIAL CREMATION, REMOVAL (Specify) 23B. DATE **JUN 19 1965** 23C. NAME of CEMETERY or CREMATORY **Oak Lawn** 23D. LOCATION (City, town, or county) (State) **Baltimore Md.**

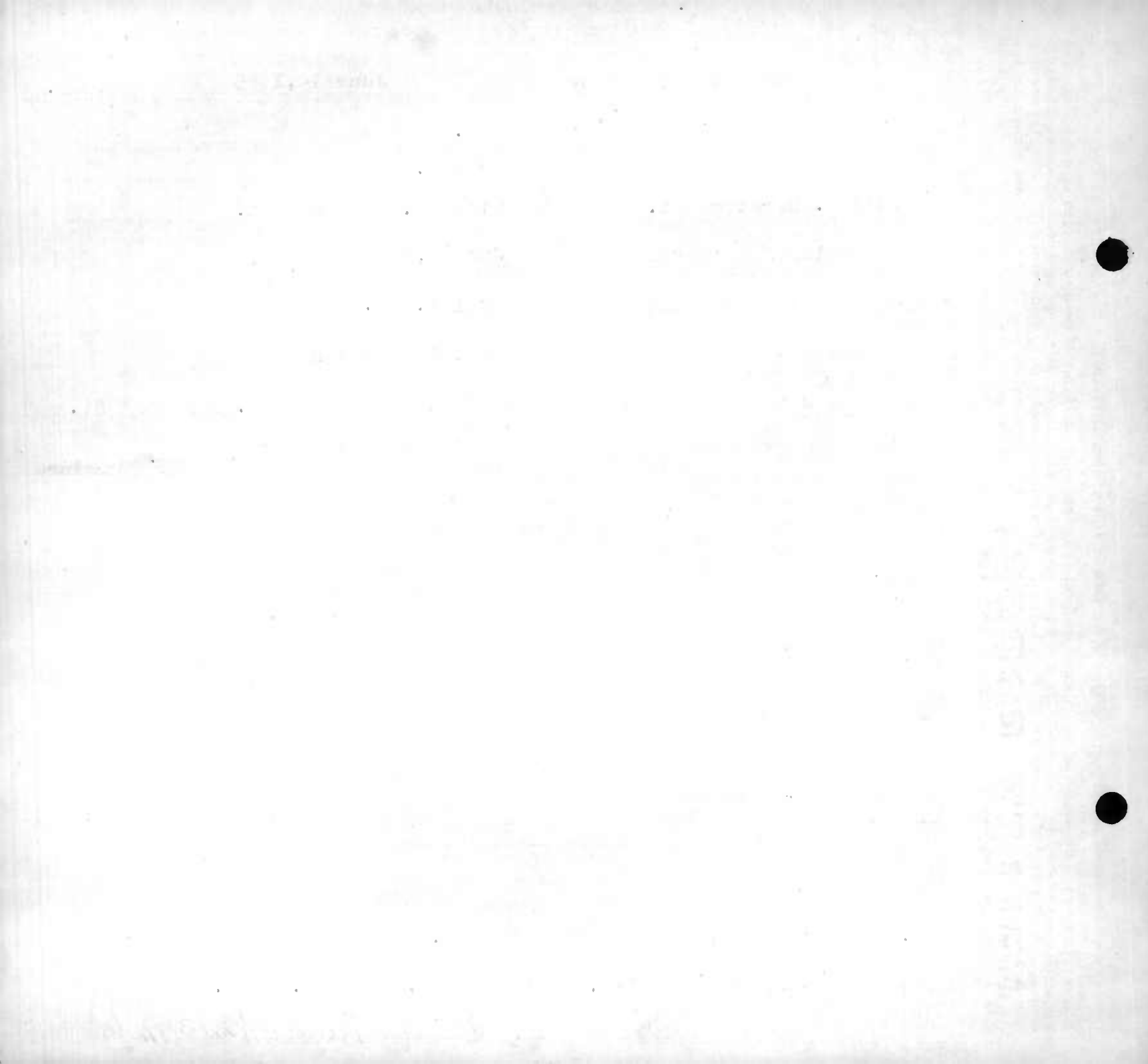
24A. DATE REC'D BY HEALTH DEPT. **JUN 18 1965** 24B. NAME OF REGISTRAR **Robert E. Farley, M.D.** 24C. FUNERAL DIRECTOR **Huntley Myrtle** ADDRESS **2334 Jefferson H.**



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6377				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6377	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) John Albert Horsey				2. DATE AND HOUR OF DEATH June 14, 1965 6:30 p. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1922 W. Saratoga St.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 20-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 1922 W. Saratoga St.			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 3, 1896	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10B. KIND OF BUSINESS OR INDUSTRY Club		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Horsey				14. MOTHER'S MAIDEN NAME Fannie Jackson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W 1		16. SOCIAL SECURITY NO. 212 09 0740		17. INFORMANT ADDRESS Elise Horsey 1922 W. Saratoga St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Abdominal Carcinoma- Metastasis				INTERVAL BETWEEN ONSET AND DEATH Undetermined			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 9/11/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/49 19 to 6/11 19 65 , that (I) (we) last saw the deceased alive on 6/11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE J. Preston Grant				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) J. Preston Grant,				23D. ADDRESS M.D. 601 N. Carrollton Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 18/65		24C. NAME of CEMETERY or CREMATORY Balto. National Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Jank...		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 319 N. Schowden St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6378		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6378	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Joseph Butler			June 14, 1965 6:35 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217			A. STATE Maryland B. COUNTY Baltimore		
5. SEX Male			6. RACE Negro		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed			8. DATE OF BIRTH 8-15-1894		
9. AGE (In years last birthday) 70			10. CITIZEN OF WHAT COUNTRY? USA		
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Louis Butler			14. MOTHER'S MAIDEN NAME Annie P		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 219-01-9408		
17. INFORMANT Louise Butler			ADDRESS 726 N. Carrollton Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Thromboses			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 18, 1965 to June 14, 1965, that (I) (we) last saw the deceased alive on June 14, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.					
23A. SIGNATURE Harris Schnabel, M.D.			23B. DATE SIGNED June 14, 1965		
23C. PHYSICIAN'S NAME (Type) Harris Schnabel, M.D.			23D. ADDRESS 1514 Division Street		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 18, 1965		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. Balto. Md.	
24D. LOCATION (City) town, or county (State)		25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.A.	
25C. FUNERAL DIRECTOR Williams Funeral Home 399 Schroeder St.		25D. ADDRESS			

Charles T. Johnson
Baltimore

John Johnson, Jr.
Baltimore

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIE JACKSON

2. DATE AND HOUR PRONOUNCED DEAD

June 17, 1965 10:10 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

43

South Baltimore Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1228 N. Gilmore St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 13, 1902

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Philip Jackson

14. MOTHER'S MAIDEN NAME

Novella

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Julia Jackson 1228 N. Gilmore St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m. WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
6-17-6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-21-65

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Pk.

23D. LOCATION

(City, town, or county)

(State)

Arbutus, Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 18 1965

24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

ADDRESS

George A. Klor 1348 N. Calhoun St.

WALLEY FORD

FUNERAL DIRECTOR: IMPORTANT

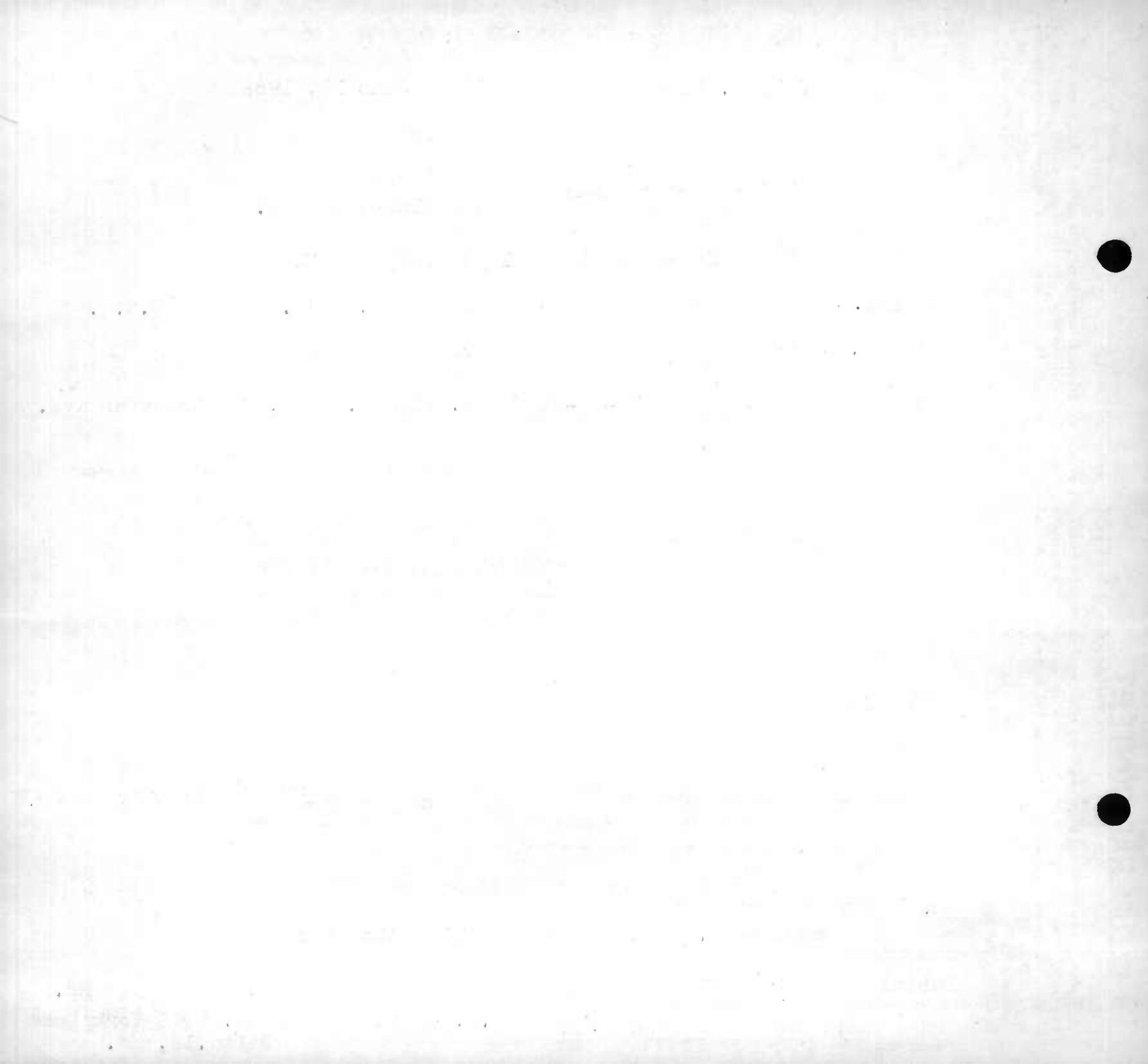
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPT.				BIRTH NO. 65 6380		CERTIFICATE OF DEATH		Registered No. 65 6380	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
Rebecca Parker				June 15, 1965		7:15 a. m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2206 Bryant Ave.				A. STATE B. COUNTY Baltimore Maryland					
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					
				D. STREET ADDRESS (If rural, give location) 2206 Bryant Ave					
5. SEX Female		6. RACE Negro		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 6/12/80		9. AGE (In years last birthday) 85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Willis Allen				14. MOTHER'S MAIDEN NAME Mary Marshall					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Emma Herndon 2206 Bryant Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Cardiac Infarction</u> DUE TO (B) <u>Acute lower bowel hemorrhage</u> DUE TO (C) <u>Intraabdominal Ca.</u>				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> 19 <u>62</u> to <u>June</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>6/13</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>F. W. Washington Jr.</u> M.D.				23B. DATE SIGNED <u>6/18/65</u>					
23C. PHYSICIAN'S NAME (Type) <u>F. W. Washington Jr.</u> M.D.				23D. ADDRESS <u>2309 Druid Hill Ave</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/19/65		24C. NAME OF CEMETERY or CREMATORY Western Star Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Co. Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965				25B. NAME OF REGISTRAR <u>Robert E. Fairley, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>George H. Klen 1348 N. Calhoun St</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

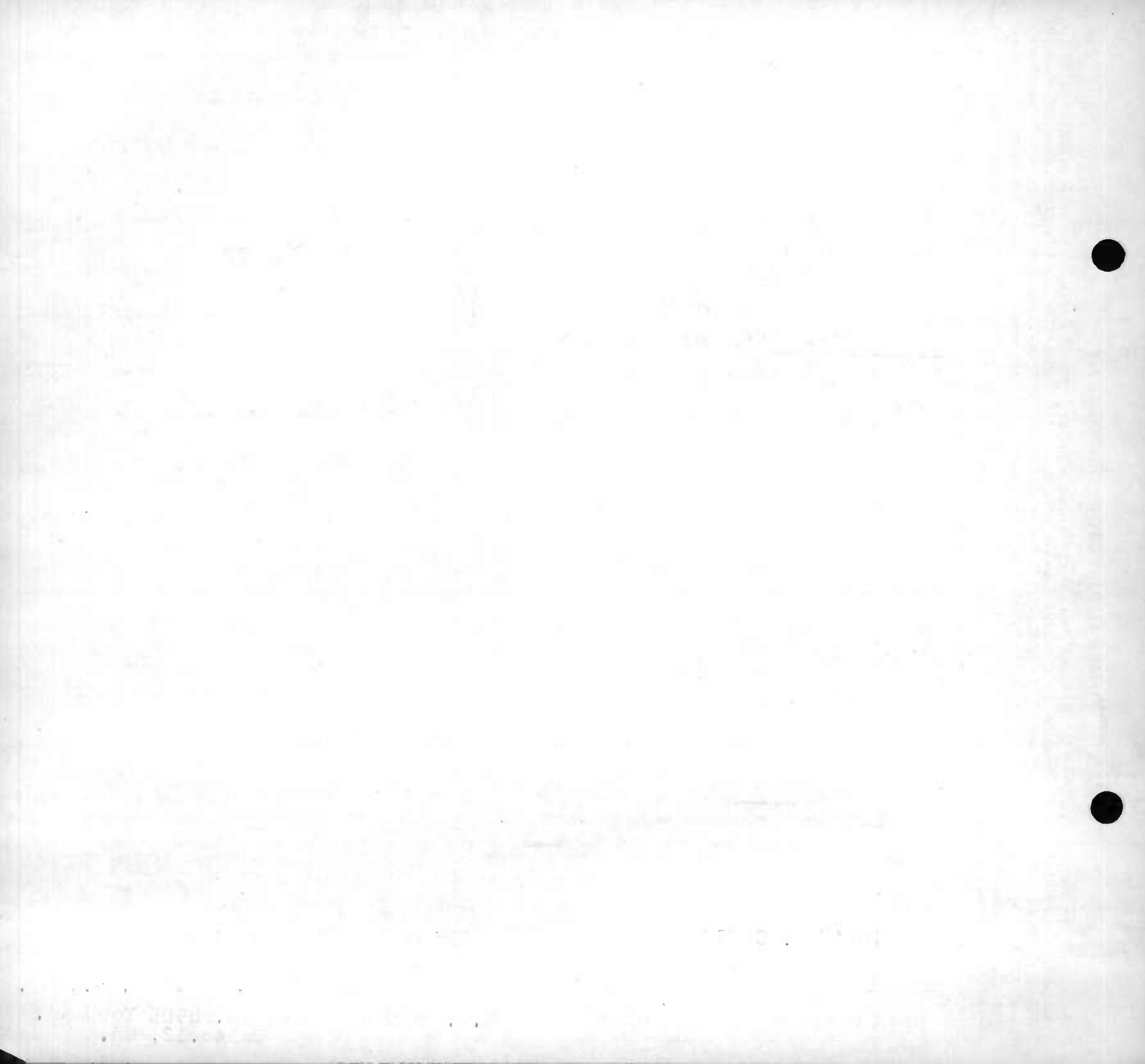
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6381	
BIRTH NO. 65 6381		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John S. Clancy		2. DATE AND HOUR OF DEATH June 17, 1965 8:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Ardleigh Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-13 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 402 Ilchester Ave.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 12/25/1893	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10B. KIND OF BUSINESS OR INDUSTRY Office	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James E. Clancy			14. MOTHER'S MAIDEN NAME Bridget Duggan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-9128	17. INFORMANT ADDRESS Mrs. Helen S. Mason, 402 Ilchester Ave.		
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cardiac Decompensation DUE TO (B) Generalized Atherosclerosis DUE TO (C) Arteriosclerotic C.V.D. INTERVAL BETWEEN ONSET AND DEATH 1 wk.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-16-1965 to 6-17-1965 , that (I) (we) last saw the deceased alive on 6-16-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lawrence J. Shimanek M.D.				23B. DATE SIGNED 6-18-65	
23C. PHYSICIAN'S NAME (Type) Lawrence J. Shimanek		23D. ADDRESS 3711 Falls Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/19/1965	24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6382	
BIRTH NO. 65 6382		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Polly M. Morison		2. DATE AND HOUR OF DEATH 6-16-65 6 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hosp		A. STATE Maryland B. COUNTY 27-12			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 2 Wyndhurst Ave			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) m	8. DATE OF BIRTH 9-14-87	9. AGE (in years last birthday) 78 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) N. Carolina	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME FREDERICK MAGRUDER Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Son - Robt. Morison	
				ADDRESS GARTH 551 Dunsford	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Right Cerebrovascular hemorrhage 11 days DUE TO (B) Arteriosclerotic cardiovascular dis DUE TO (C)			
		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-5-1965 to 6-16-1965 , that (I) (we) last saw the deceased alive on 6-16-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Miriam R. Cohen				23B. DATE SIGNED 6-16-65	
23C. PHYSICIAN'S NAME (Type) MIRIAM R. COHEN				23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/18/1965		24C. NAME OF CEMETERY or CREMATORY Druid Ridge	
				24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4005 York Rd. Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6383				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6383	
M.E. CASE NO.				1. NAME OF DECEASED			
				2. DATE AND HOUR OF DEATH			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
5. SEX				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
6. RACE				D. STREET ADDRESS (If rural, give location)			
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				E. DATE OF BIRTH			
8. DATE OF BIRTH				9. AGE (In years last birthday)			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from				22. I certify that (I) (this hospital) attended the deceased from			
23A. SIGNATURE				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
25C. FUNERAL DIRECTOR				ADDRESS			

UNITED STATES HOSPITAL

W. L. C. HEN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6384		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 6384	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>William R. Bixler</u>		2. DATE AND HOUR OF DEATH <u>6-16-65</u> <u>7:28 P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A, STATE <u>MARYLAND</u> B, COUNTY <u>Balto</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Towson</u> <u>53-00</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MERCY HOSPITAL</u>		D. STREET ADDRESS (If rural, give location) <u>117 LAPAIX LANE</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>1-7-86</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED TREASURER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>B & O RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>INDIANA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>WILLIAM R. BIXLER</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>MRS. EVA M. CAMPBELL, 507 HOLT ROAD, INDIANAPOLIS, IND.</u>	
18. <u>370.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>MESENTERIC THROMBOSIS</u>		CAUSE OF DEATH (A) <u>MESENTERIC THROMBOSIS</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>ASCVD & AT. FIBRATION</u>			
19A. DATE OF OPERATION <u>6-15-65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>MESENTERIC THROMBOSIS</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <u>6-14</u> 19 <u>65</u> to <u>6-16</u> 19 <u>65</u> , that (1) we last saw the deceased alive on <u>6-16</u> 19 <u>65</u> and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (1) we (did) did not view the body after death.			
23A. SIGNATURE <u>Salvatore R. Donohue</u> M.D.		23B. DATE SIGNED <u>6-16-65</u>		23C. PHYSICIAN'S NAME (Type) <u>SALVATORE R. DONOHUE</u> M.D.	
23D. ADDRESS <u>MERCY HOSP.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/19/1965</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Crown Hill</u>		24D. LOCATION (City, town, or county) (State) <u>Indianapolis, Ind.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 18 1965</u>	
25B. NAME OF REGISTRAR <u>Robert E. Farkas</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>		25D. ADDRESS <u>4905 York Rd. Baltimore 12, Maryland</u>	

CERTIFICATE OF DEATH

BIRTH NO.

65 6385

M.E. CASE NO.

1. NAME OF DECEASED

(Type of Print)

WILLIAM KENNETH CUMMING

2. DATE AND HOUR OF DEATH

JUNE 17, 1965 12⁵⁵ P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)44
Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALTIMORE

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

211 W. 2nd STREET

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

12-26-89

9. AGE (In years
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

HARFORD CO. SCHOOL

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

WILLIAM K. CUMMING 319-18-2288

14. MOTHER'S MAIDEN NAME

LELIA STOKES

15. Was Deceased Ever in U. S. Armed Forces?
(If yes, give war or dates of service)

NO

WWI

16. SOCIAL
SECURITY NO.

XXXXXXXX

17. INFORMANT

MRS. GAINES CUMMING

ADDRESS

BAMG

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.CAUSE OF DEATH
AORTIC DISSECTING ANEURYSM(A) ~~RUPTURE INTO PERICARDIUM~~
DUE TO RUPTURE INTO PERICARDIUMINTERVAL BETWEEN
ONSET AND DEATH

2 MINUTES

(B) ARTERIO SCLEROSIS
DUE TO

10 YEARS

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

ABDOMINAL AORTIC ANEURYSM

19A. DATE OF OPERATION

6-17-65

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

ABDOMINAL ANEURYSM

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-14-65 19 to 6-17-65 19
that (I) (we) last saw the deceased alive on 6-17-65 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Fred O. Smith

M.D.

Attending
Phys.Mod.
DirectorStaff
Phys.

23B. DATE SIGNED

6-17-65

23C. PHYSICIAN'S
NAME (Type)

DR. FRED O. SMITH

M.D.

23D. ADDRESS

Union Memorial Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/21/1965

24C. NAME of CEMETERY or CREMATORY

Winchester

24D. LOCATION

(City, town, or county)

(State)

Winchester

Ky.

25A. DATE REC'D BY HEALTH DEPT.

JUN 18 1965

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.

Baltimore 12, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

DR. FRED O. SMITH

RECEIVED

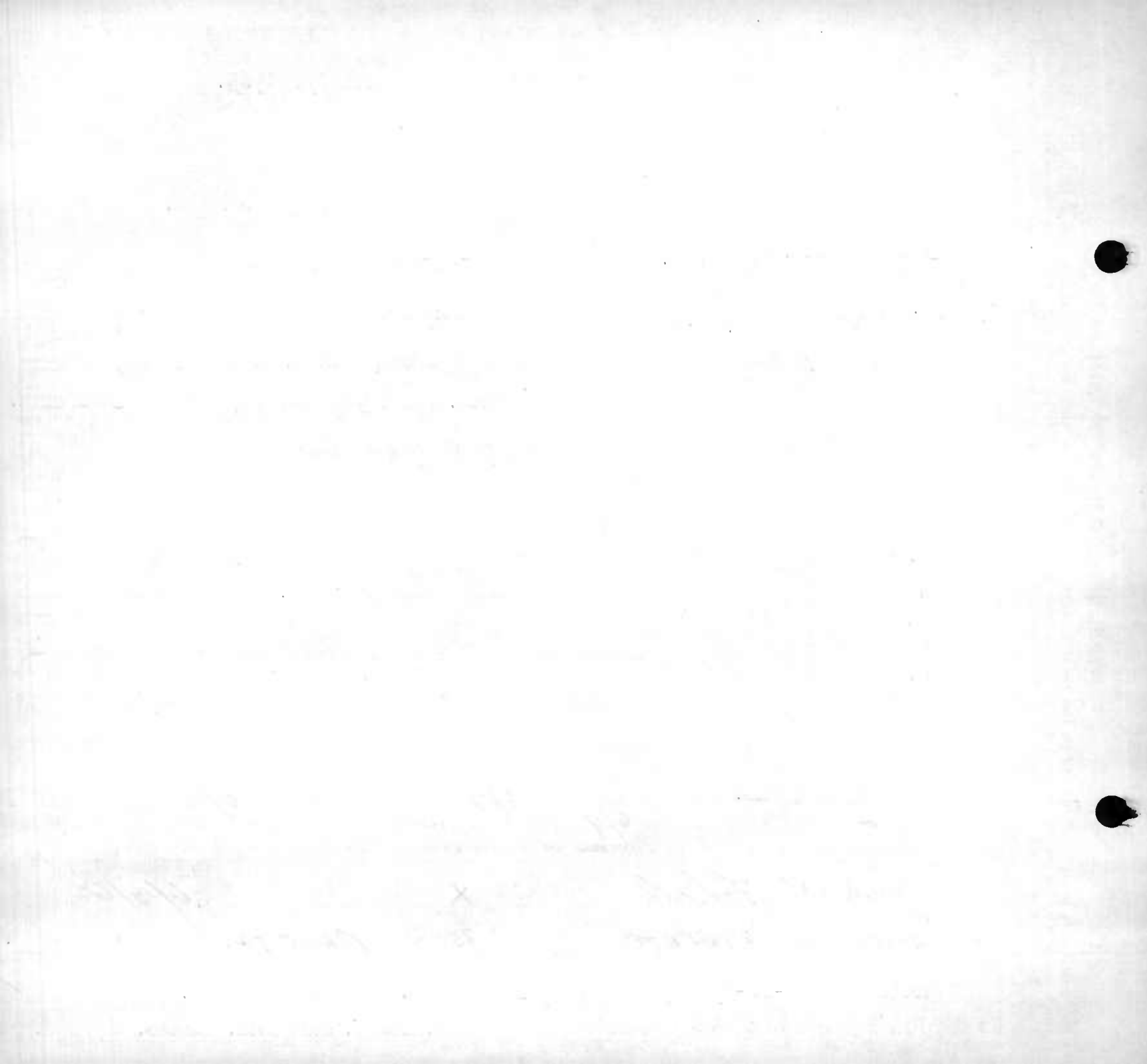
JUN 18 1965

17112 . 1310.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

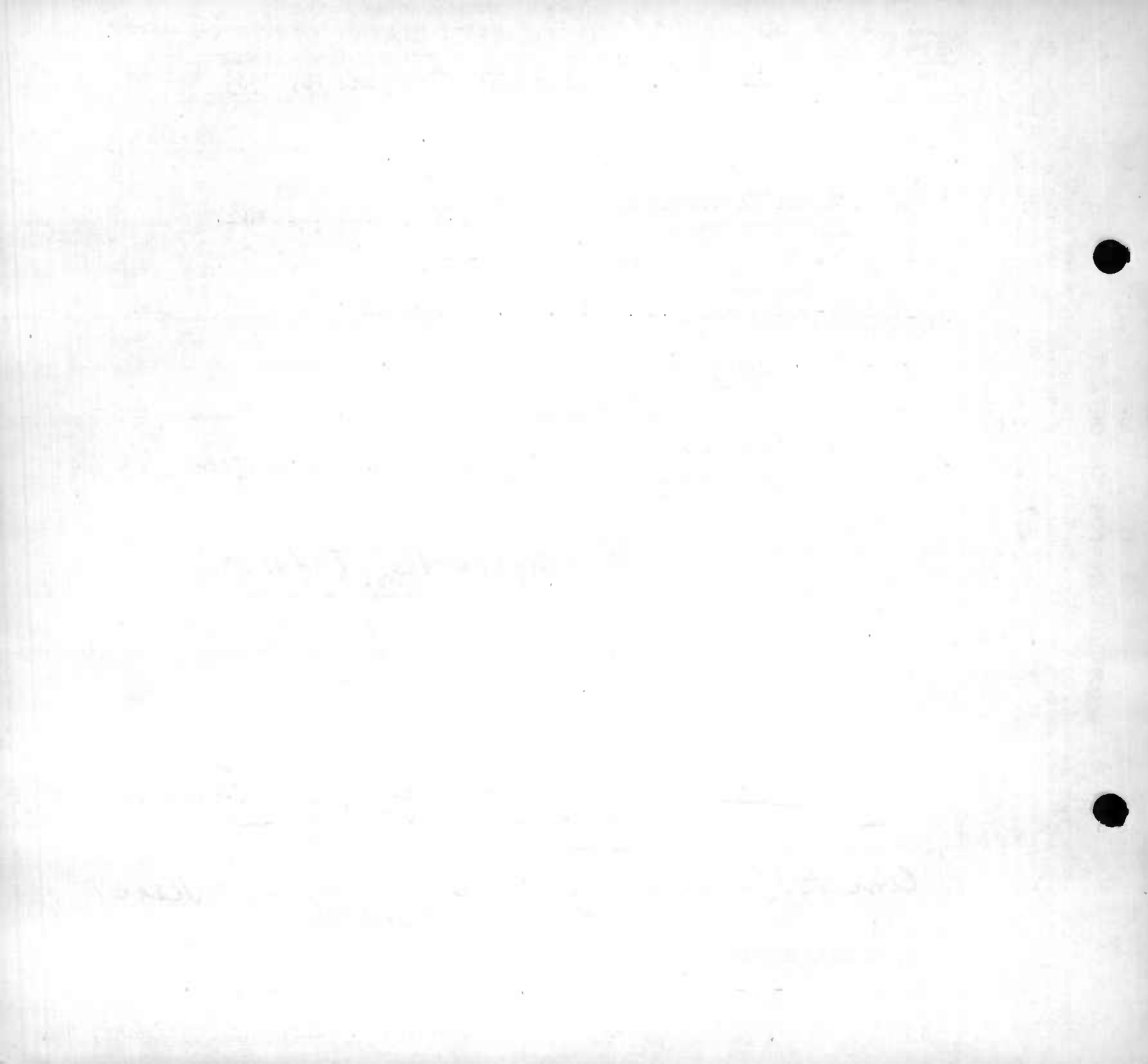
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6386	
BIRTH NO. 65 6386		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Martha Taylor		2. DATE AND HOUR OF DEATH June 17, 1965. 7³⁰ P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital			A. STATE Md. B. COUNTY 26-36		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 6309 Elliott St.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED widowed	8. DATE OF BIRTH 5-14-1886	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Emmore		14. MOTHER'S MAIDEN NAME Clara (Last name not known)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Ruth Goykow, 6847 Queens Pkwy Rd.	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary atherosclerosis (stroke)			CAUSE OF DEATH Coronary atherosclerosis (stroke)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/3 1965 to 6/17 1965 , that (I) (we) last saw the deceased alive on 6/17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph R. Liberto			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/18/65
23C. PHYSICIAN'S NAME (Type) JOSEPH R. LIBERTO			23D. ADDRESS 3508 BANK ST.		
24A. BURIAL CREMATION REMOVAL (Specify) burial	24B. DATE 6-21-65	24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. 14, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

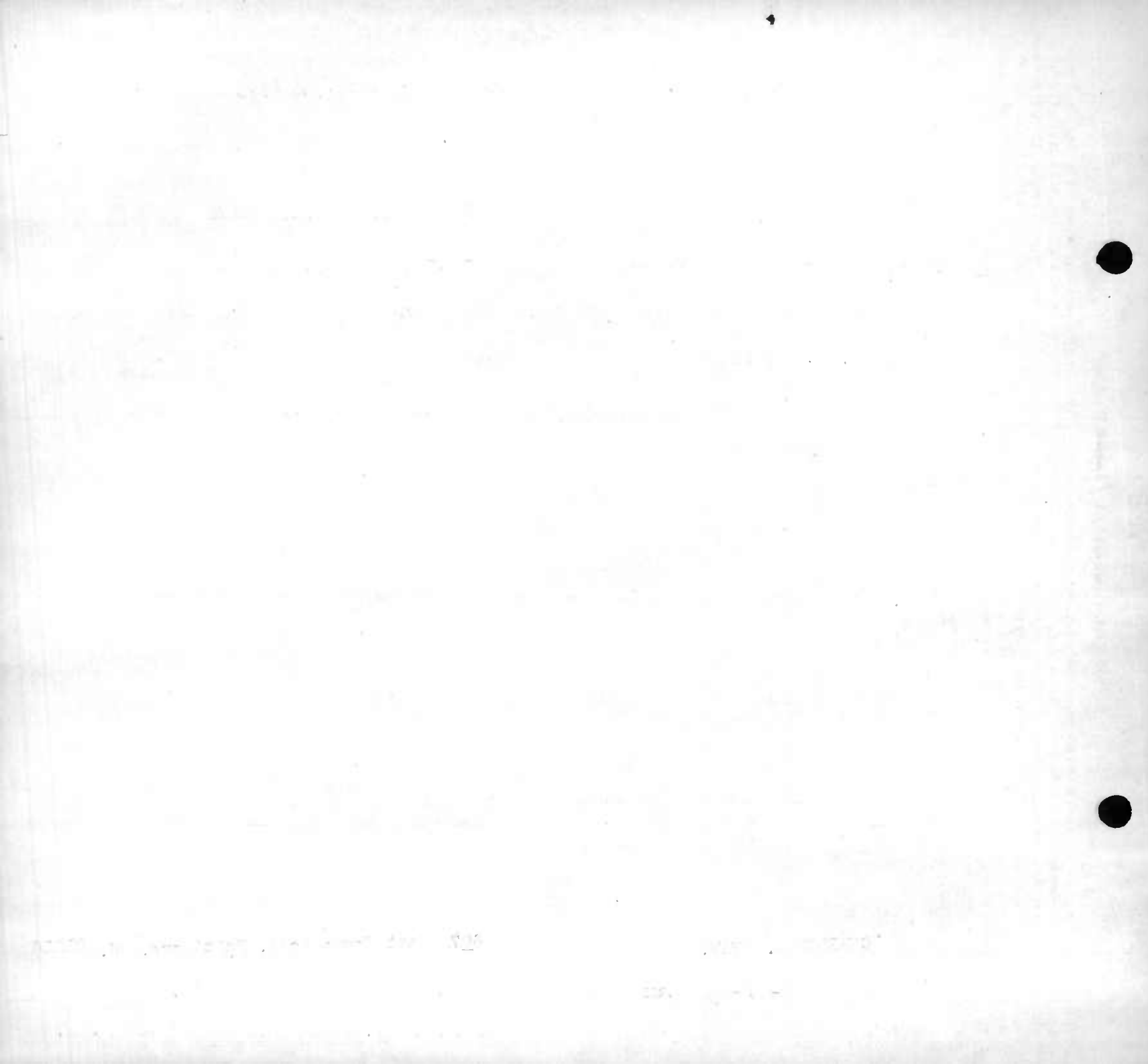
BIRTH NO. 65 6387				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6387	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Donald M. Engelmyer</i>				2. DATE AND HOUR OF DEATH <i>June 16, 1965 10:30 P. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Md.</i>		B. COUNTY <i>9-04</i>	
5. SEX <i>male</i>				6. RACE <i>white</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	
8. DATE OF BIRTH <i>6-3-1903</i>		9. AGE (In years last birthday) <i>62</i>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor-Baltimore Gas & Elec. Co.</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Michael C. Engelmyer</i>				14. MOTHER'S MAIDEN NAME <i>Mary A. McDonald</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>212055743</i>		17. INFORMANT <i>Mrs Minnie Engelmyer</i>		ADDRESS <i>same</i>	
1B. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>Myocardial Infarction</i> DUE TO (B) DUE TO (C) <i>Myocardial Infarction, old</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hour</i> <i>21 mos.</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Oct. 4 1960</i> to <i>June 16 1965</i> , that (I) (was) last saw the deceased alive on <i>June 2 1965</i> and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) did not view the body after death.							
23A. SIGNATURE <i>Com H. K. Rimmer, Jr.</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>June 18, 1965</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>6-21-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Moreland Mem. Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 18 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairley</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc Baltimore, Md.</i>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6388		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6388	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Maurice C. Kilbourne		June 17, 1965		4:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY 27-09	
1518 Northbourne Road		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		1518 Northbourne Road	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
male	white	married	2-28-1908	57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
C & P Telephone Company Employee				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John V. Kilbourne		Kate Maslin		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		212050733		Kathryn Kilbourne	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
1. 162-1 I		Bronchogenic Carcinoma		1 year	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 1952 to 19, that (I) (we) last saw the deceased alive on June 15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Charles E. Shaw M.D.		18 June 65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
CHARLES E. SHAW		607 West Joppa Road, Baltimore, Md. 21204			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
burial		6-21-65		David Ridge Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 18 1965		Robert E. Farber		Leonard J. Ruck Inc Baltimore, Md.	

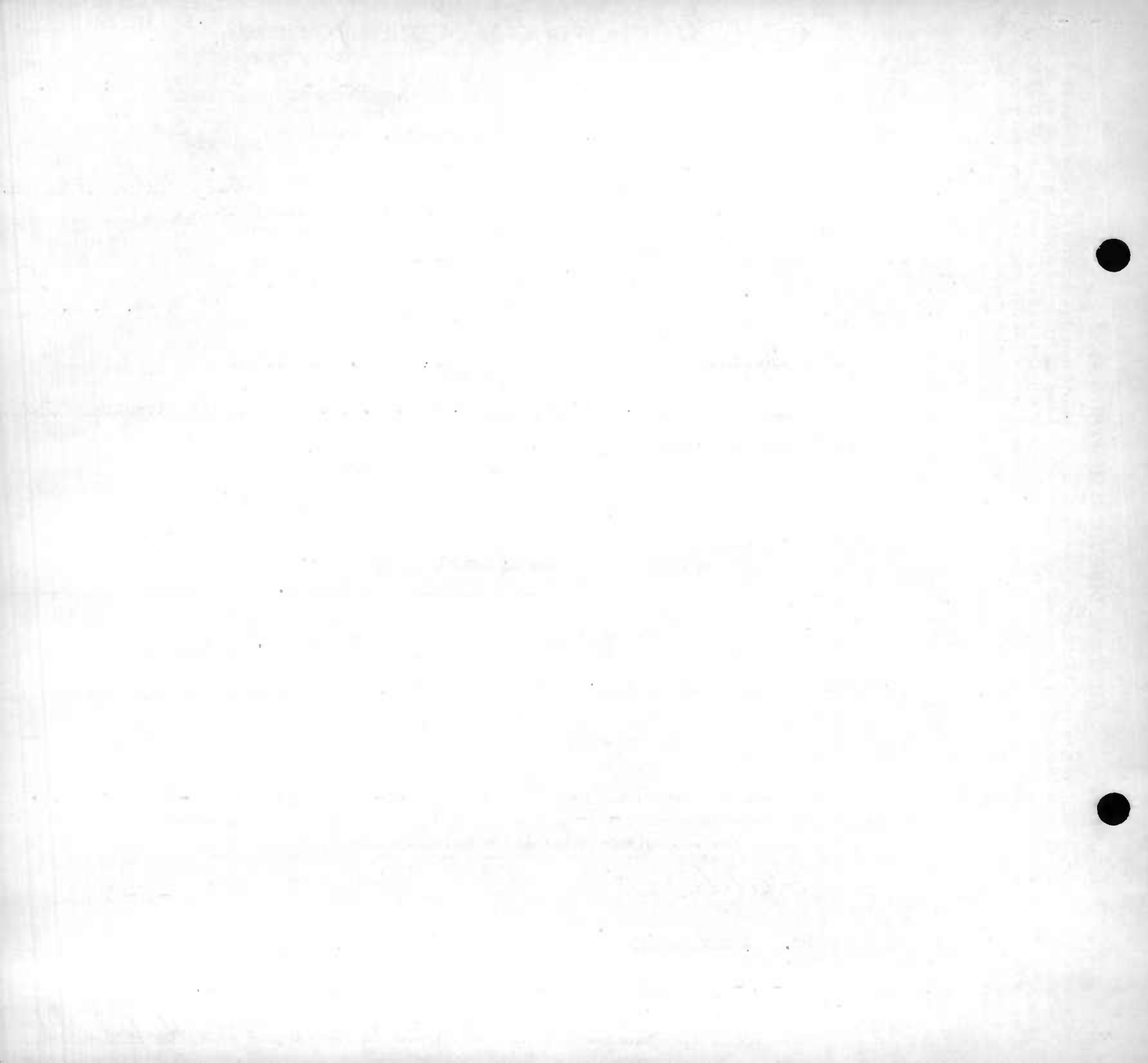


42-78-35 AM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

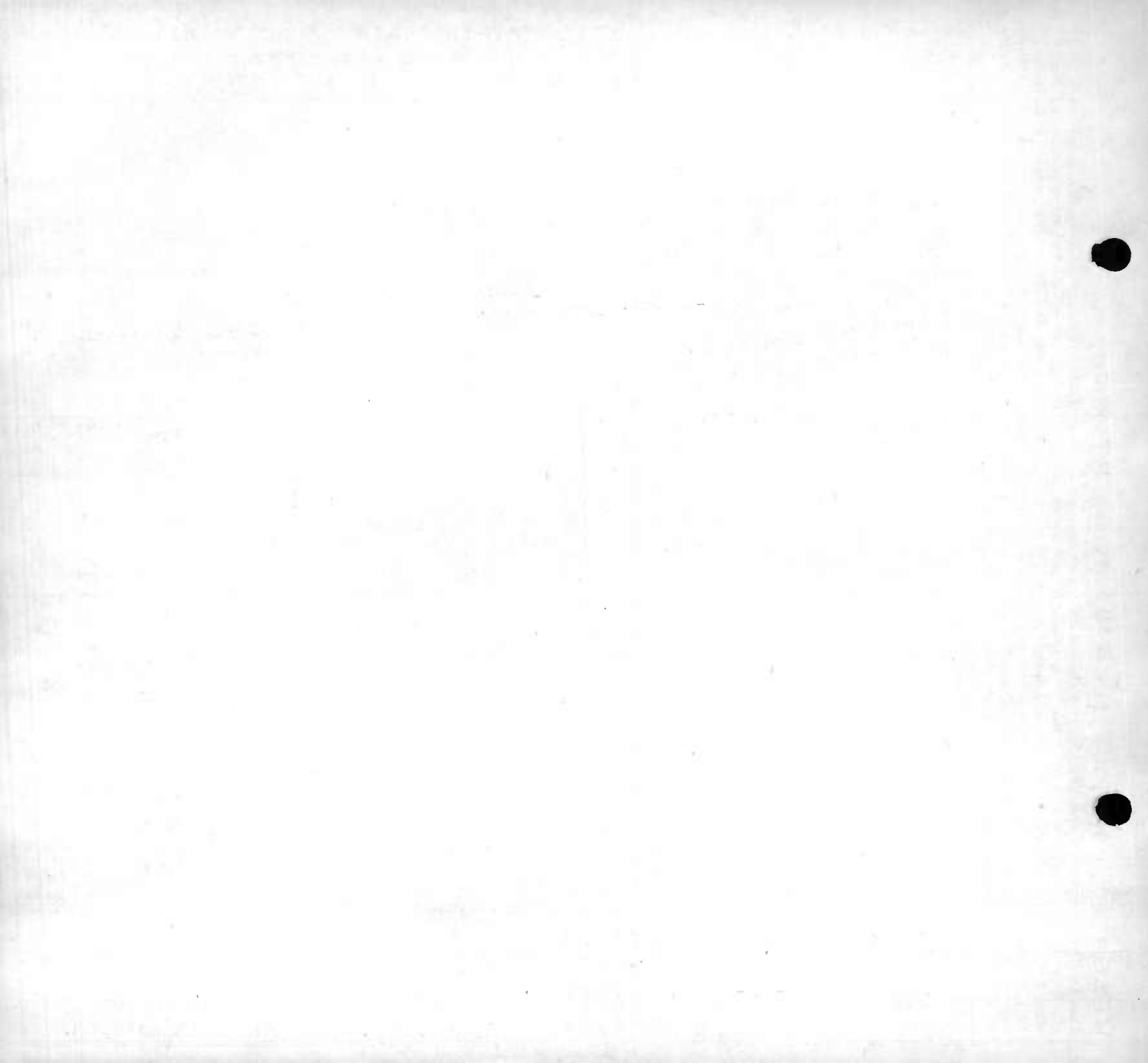
BIRTH NO. 65 6389		BALTIMORE CITY HEALTH DEPT. CERTIFICATE OF DEATH		Registered No. 65 6389	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Edna Earle Archer		2. DATE AND HOUR OF DEATH 6-17-65 6:50 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland, Baltimore B. COUNTY Calto C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rural D. STREET ADDRESS (If rural, give location) 6615 Raven Hill Rd. 2802 Linwood Avenue #21224			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3-9-89	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William Barnes		14. MOTHER'S MAIDEN NAME Laura J. Robinson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217186583A		17. INFORMANT RECORDS: B.C.H. 4940 Eastern Avenue #21224	
18. 570.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Small Bowel Gangrene due to Boldus.		CAUSE OF DEATH (A) Acute Renal Failure DUE TO (B) Pulmonary Embolism DUE TO (C) Small Bowel Gangrene due to Boldus.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 6-15-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene Small Bowel		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-5-19 65 to 6-17-19 65, that (I) (we) last saw the deceased alive on 6-17-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Howard Rathbun		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-17-65	
23C. PHYSICIAN'S NAME (Type) Dr. Howard Rathbun		23D. ADDRESS 4940 Eastern Avenue #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 6-21-65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Md.		24E. STATE (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR L. J. Ruckelshaus	
25D. ADDRESS 5305 Harford Rd.					



RELEASED ON APPROVAL FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6390				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6390	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MEISEL, CASPER, GEORGE				2. DATE AND HOUR OF DEATH JUNE 17 th , 1965 11:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3116 WHITE AVE BALTIMORE MD, 21214				A. STATE B. COUNTY MARYLAND 27-44			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 3116 WHITE AVE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10/4/1890		9. AGE (In years lost birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MACHINIST - Balto. City Dept.		10B. KIND OF BUSINESS OR INDUSTRY FIRE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MEISEL, GEORGE, NICHOLAS				14. MOTHER'S MAIDEN NAME BUNNEL, ANNA BABBARA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 220446804		16. SOCIAL SECURITY NO. BY 220446804		17. INFORMANT ANNA A. MEISEL SON, 3116 WHITE AVE, BALTO MD		ADDRESS	
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH I HYPERTENSIVE HEART DISEASE DUE TO II SCLEROTIC CARDIOVASCULAR DISEASE DUE TO III AORTIC Aneurysm due to atherosclerosis.			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 6-18- to 19 65, that (I) (we) last saw the deceased alive on 6-18- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Edmund Kasaitis				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/18/1965 12:05 A.M.	
23C. PHYSICIAN'S NAME (Type) EDMUND KASAITIS				23D. ADDRESS M.D. 8713 HARFORD RD; BALTIMORE MD 21234			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 6-21-65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 18 1965		25B. NAME OF REGISTRAR Robert E. Fidler		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc		ADDRESS Baltimore, Md.	



65 6391

BALTIMORE CITY HEALTH DEPARTMENT

65 6391

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HENRY J. HAMMELMAN

2. DATE AND HOUR PRONOUNCED DEAD

6/19/65 5:50 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3105 Ellicott St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

May 4, 1897

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Sparrows Point

11. BIRTHPLACE (State or foreign country)

Baltimore County, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles Hammelman

14. MOTHER'S MAIDEN NAME

Margaret Behr

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

Yes

8-27-18

12-9-18

16. SOCIAL
SECURITY NO.

213-07-8759

17. INFORMANT

ADDRESS

Jerome Hammelman 1503 33rd Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

6/19/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-21-1965

23C. NAME OF CEMETERY or CREMATORY

Sacred Heart

23D. LOCATION

(City, town, or county) (State)

Baltimore County, Maryland

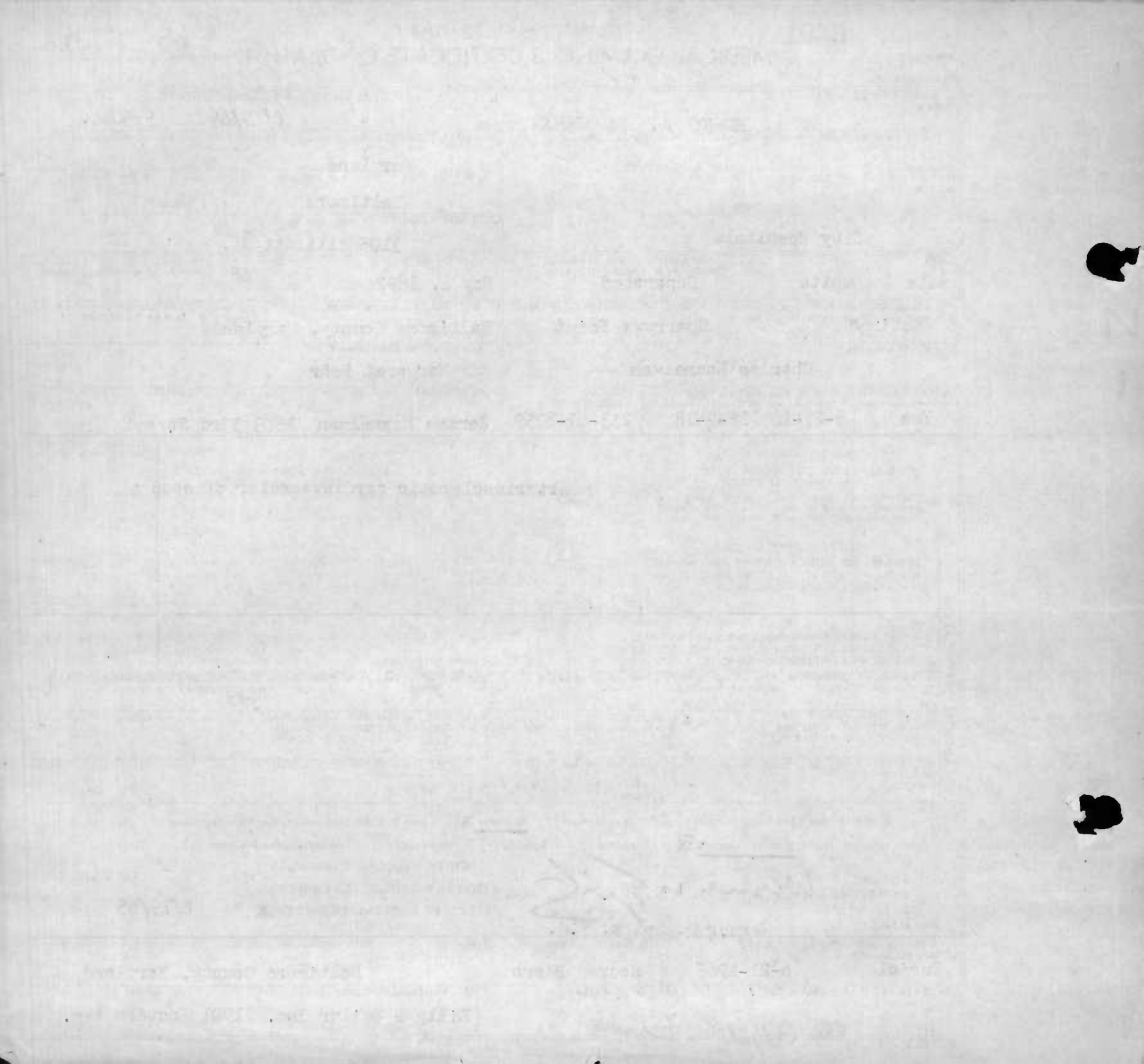
24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Lilly & Zeiler Inc. 1901 Eastern Ave.



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BERNARD O. EBBERTS

2. DATE AND HOUR PRONOUNCED DEAD

June 15, 1965

8:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2263 W. Baltimore Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2263 W. Baltimore Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

July 14, 1916

9. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Steel

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William H. Ebberts

14. MOTHER'S MAIDEN NAME

Lollie Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

212-05-8875

17. INFORMANT

ADDRESS

Bernard R. Ebberts-5474 Addington Rd

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fatty metamorphosis of liver

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE
WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-16-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/19/65

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUN 21 1965

24B. NAME OF REGISTRAR

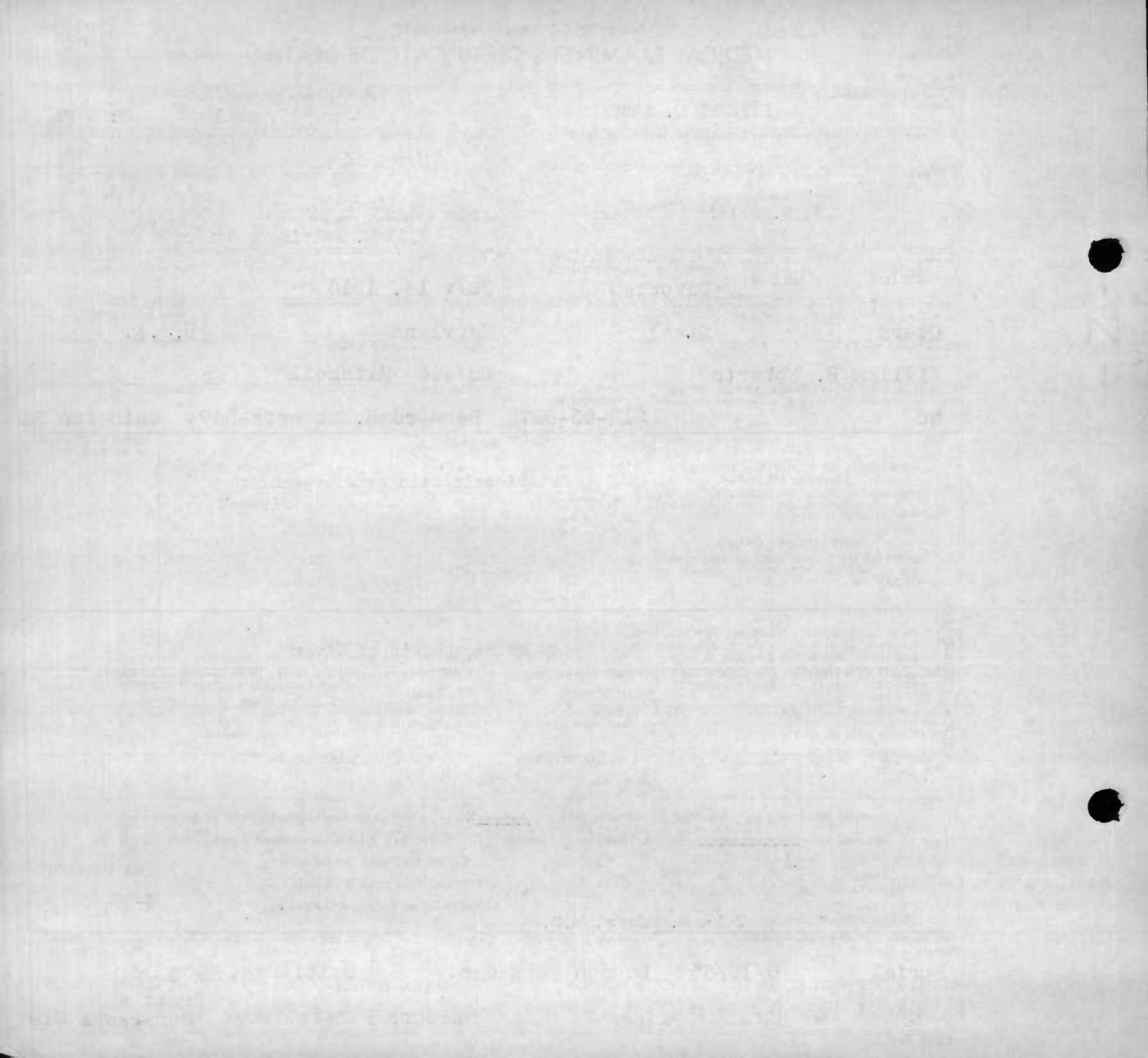
Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Walters Funeral Home Strickers Sts

Pratt &



1. **BIRTH NO.** 65 6393 **BALTIMORE CITY HEALTH DEPARTMENT** **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. 65 6393

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **CLAREN H. COLES** **2. DATE AND HOUR PRONOUNCED DEAD** 6/11/65 2:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD **4. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission)
A. STATE Washington **B. COUNTY** D.C.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) V-48
D. STREET ADDRESS (If rural, give location) 2500 Wisconsin Ave. N.W.

5. SEX male **6. RACE** white **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (specify) Married **8. DATE OF BIRTH** May 18, 1908 **9. AGE** (in years last birthday) 57 **10. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) Pharmacist **11. BIRTHPLACE** (State or foreign country) Indiana **12. CITIZEN OF WHAT COUNTRY?** USA

13. FATHER'S NAME Silas Jefferson Coles **14. MOTHER'S MAIDEN NAME** Ida Overmyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; If yes, give war or dates of service) No **16. SOCIAL SECURITY NO.** 578-03-8901 **17. INFORMANT** Wife - Audra B. Coles, Wash. D.C. **ADDRESS**

18. CAUSE OF DEATH **INTERVAL BETWEEN ONSET AND DEATH**
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Overdose of barbiturates
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.)
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic cardiovascular disease

19A. DATE OF OPERATION **19B. CONDITION FOR WHICH OPERATION WAS PERFORMED** **20A. AUTOPSY?** (Yes or No) yes **20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?** yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. **21B. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) hotel room **21C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location) Albion Hotel

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) unknown **21E. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☒ **21F. HOW DID INJURY OCCUR?** ingested overdose of barbiturates

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ **and that on this basis, death in my opinion resulted from:** Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *Werner U. Spitz* **CHIEF MEDICAL EXAMINER** ☐ **DATE SIGNED** 6/11/65
EXAMINER'S NAME (Type) Werner U. Spitz, M.D. **ASSISTANT MEDICAL EXAMINER** ☐ **ASSOCIATE MEDICAL EXAMINER** ☒

23A. BURIAL CREMATION, REMOVAL (Specify) Burial **23B. DATE** 6-15-65 **23C. NAME OF CEMETERY or CREMATORY** Arlington National Cem. **23D. LOCATION** (City, town, or county) (State) Arlington, Va.

24A. DATE REC'D BY HEALTH DEPT. JUN 21 1965 **24B. NAME OF REGISTRAR** Robert E. Farley, M.D. **24C. FUNERAL DIRECTOR** James E. DeVol **ADDRESS** De Vol Funeral Home - 2224 Wisc. Ave D.C.

VALLEY HORGE

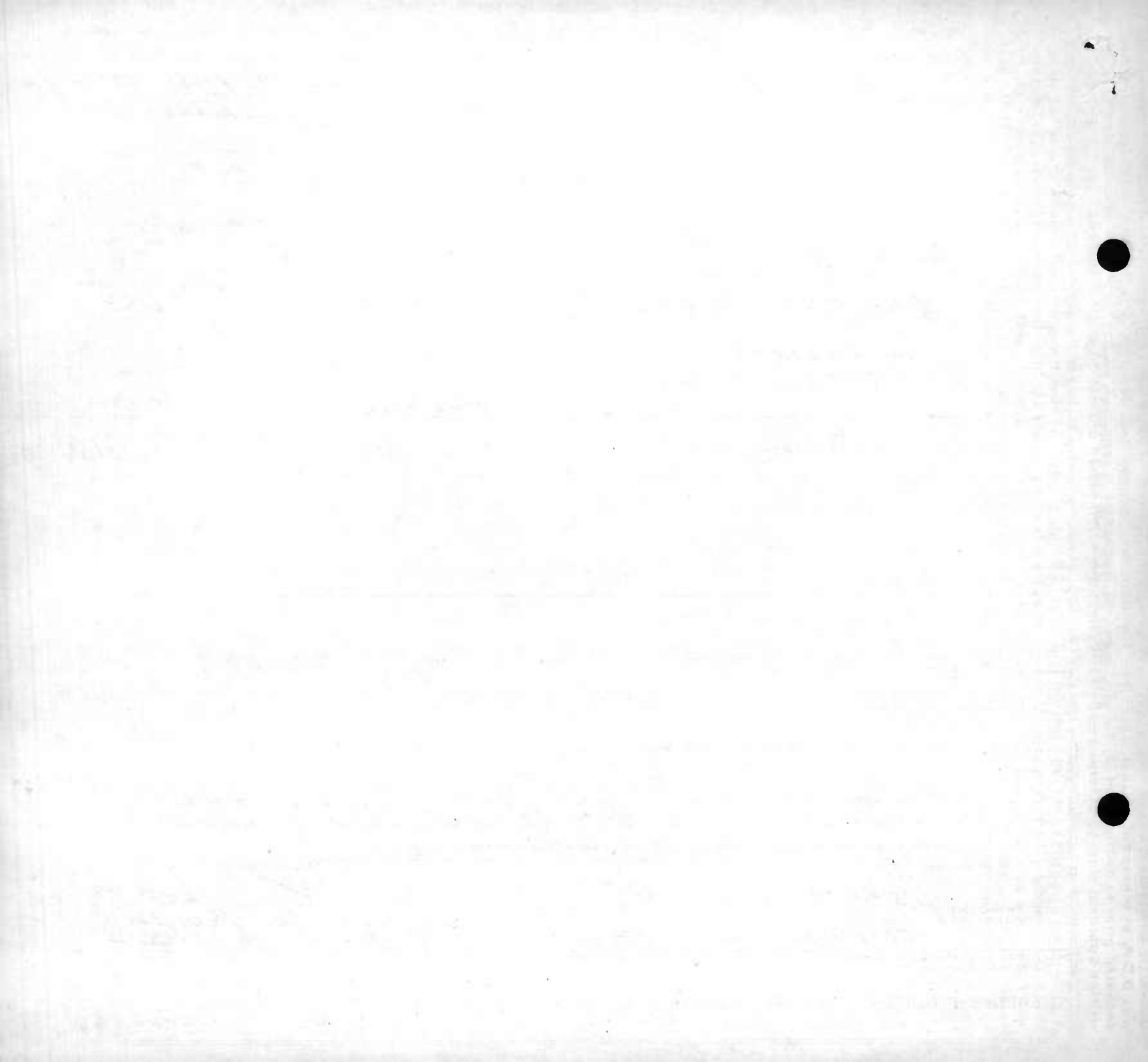
PHOTOGRAPH

11/15/1915

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

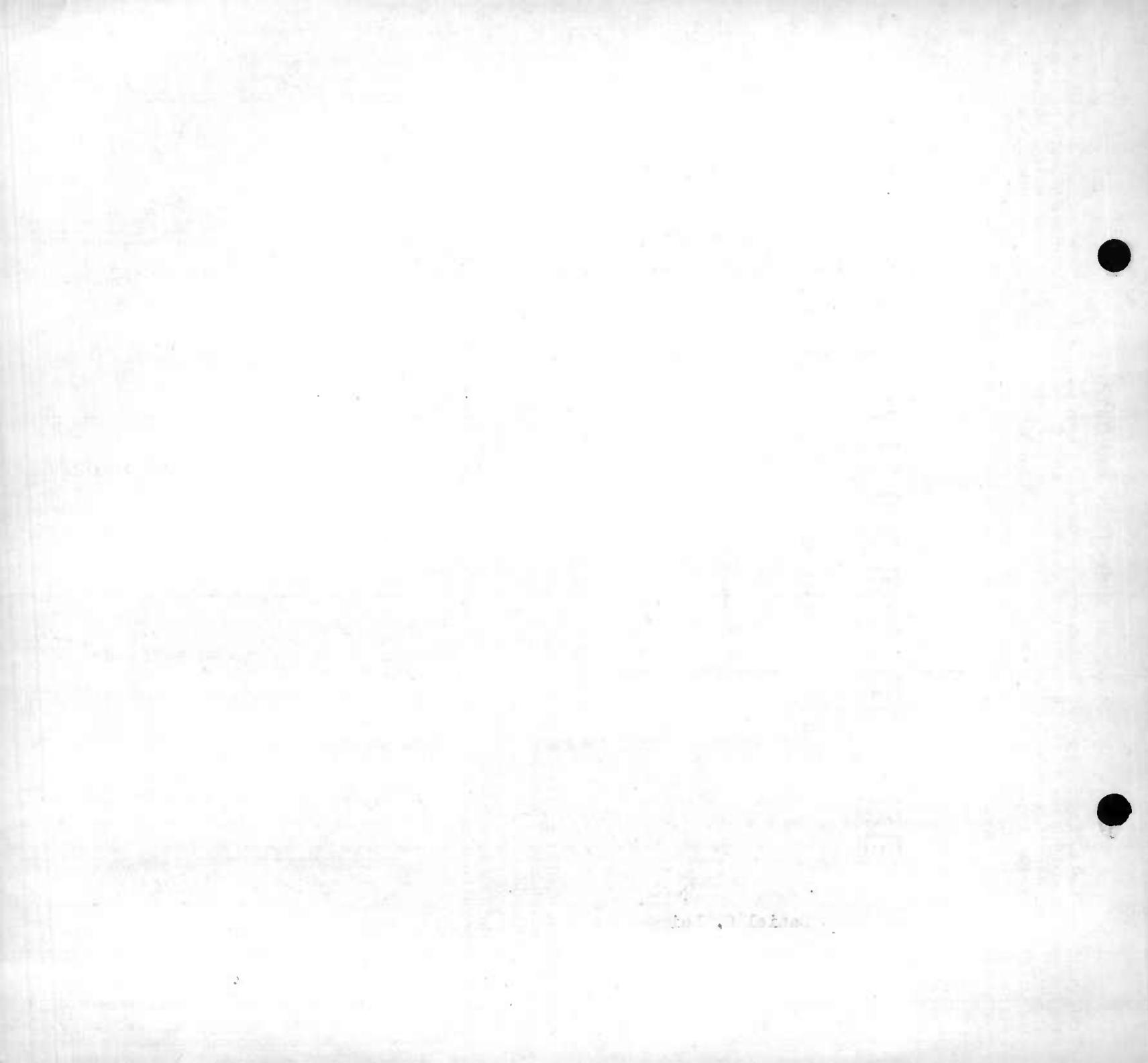
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6394	
BIRTH NO. 65 6394		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ADA V. HAMMOND			2. DATE AND HOUR OF DEATH JUNE 17, 1965 12:00 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GEN. HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE B. COUNTY MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) 237 E. NORTH AVE. D. STREET ADDRESS (If rural, give location) 12-05		
5. SEX Female	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED , DIVORCED (specify)	8. DATE OF BIRTH 9/3/76	9. AGE (In years lost birthday) 88	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAIL CLERK		10B. KIND OF BUSINESS OR INDUSTRY Gwynn Oak Park		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Squires			14. MOTHER'S MAIDEN NAME Adeline Motto		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ✓	17. INFORMANT Adeline Motto - 1195 Greenville Rd		
18. 430.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ARTEROSCLEROTIC HEART DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 17, 1965 to June 17, 1965 , that (I) (we) last saw the deceased alive on June 17, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Melen Sabunaryo			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Jun 17/65
23C. PHYSICIAN'S NAME (Type) DOCTOR M SABUNARYO			23D. ADDRESS Maryland Gen. Hospital Baltimore, Maryland		
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL	24B. DATE 6/21/65	24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cem		24D. LOCATION (City, town, or county) (State) Baltimore Co. Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS 2.8 Mac Nabb Catonsville Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

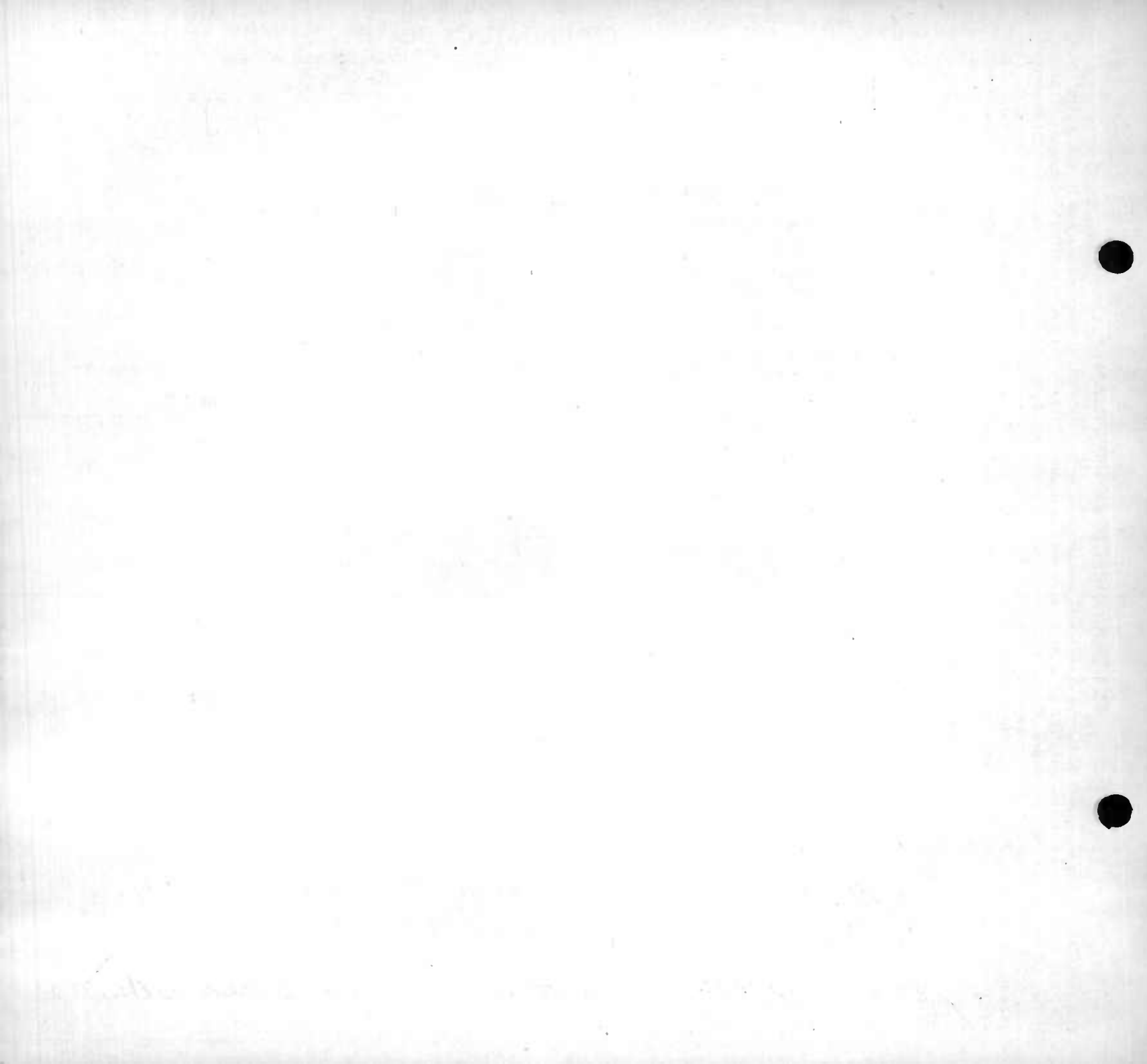
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 6395	
BIRTH NO. 65 6395		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Stevenson, John</i>		2. DATE AND HOUR OF DEATH <i>6/16/65</i> <i>11:20 a.m.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Montebello State Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>27-18</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>3408 W. Belvedere Ave.</i>			
5. SEX <i>male</i>	6. RACE <i>White</i>	7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED <input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify)		8. DATE OF BIRTH <i>1-20-1885</i>	9. AGE (In years last birthday) <i>78</i> 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Copper Smelter</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Del.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>unknown Steve Stevenson</i>				14. MOTHER'S MAIDEN NAME <i>unknown Parca Mitchell</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT ADDRESS <i>Hospital Records.</i>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>arteriosclerotic heart disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>10 months</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>11/9/64</i> 19 to <i>6/16/65</i> 19, that (I) (we) last saw the deceased alive on <i>6/16/65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Daniel G. Lai</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/16/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Daniel G. Lai</i>				23D. ADDRESS M.D. <i>2201 Argonne Drive, Baltimore 16, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-18-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>London Park Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 21 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>		25C. FUNERAL DIRECTOR <i>John C. Miller Inc.</i>		ADDRESS <i>-6415 Belair Rd.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

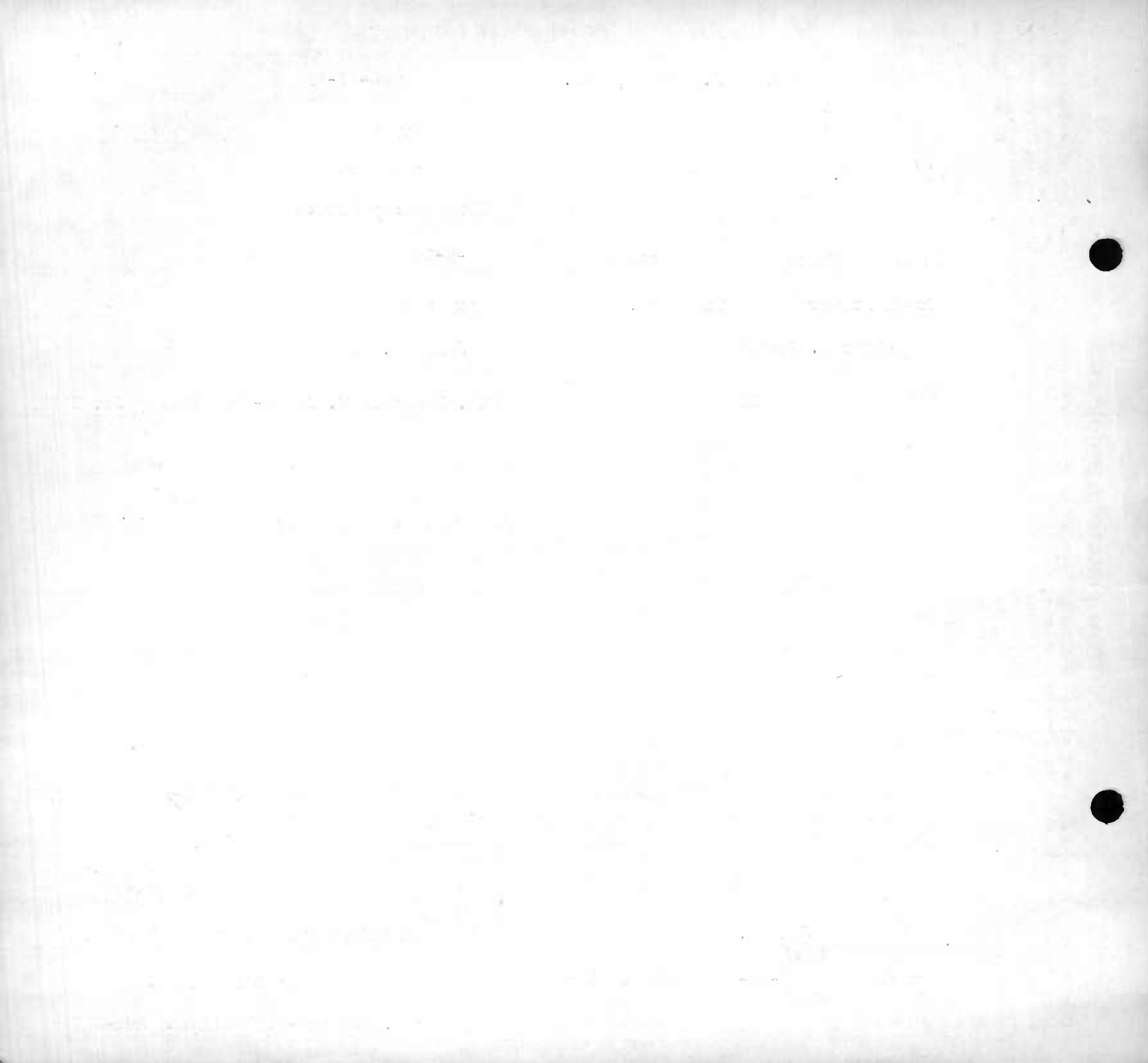
BIRTH NO. 65-15261 65 6396				BALTIMORE CITY HEALTH DEPARTMENT		65 6396	
M.E. CASE NO.				CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) HALL, BABY GIRL				2. DATE AND HOUR OF DEATH 6-18-65 9:55 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 9-08 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2130 AIKEN STREET			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 6-18-65	9. AGE (In years lost birthday) 3:35 MIN.	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME EARNEST LEVI HALL				14. MOTHER'S MAIDEN NAME MACK, MERRY LEE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. 76251 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Prematurity. (B) Massive Aspiration. (C) Primary Apnea. INTERVAL BETWEEN ONSET AND DEATH 3 HRS. 3 HRS. 3 HRS.							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/18 1965 to 6/19 1965, that (I) (we) last saw the deceased alive on 6/18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE RS Asnes, M.D.				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/18	
23C. PHYSICIAN'S NAME (Type) Russell S Asnes				23D. ADDRESS J H H			
24A. BURIAL CREMATION, REMOVAL (Specify) YES		24B. DATE 6/19/65		24C. NAME OF CEMETERY or CREMATORY cremation		24D. LOCATION (City, town, or county) (State) Johns Hopkins Hospital	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

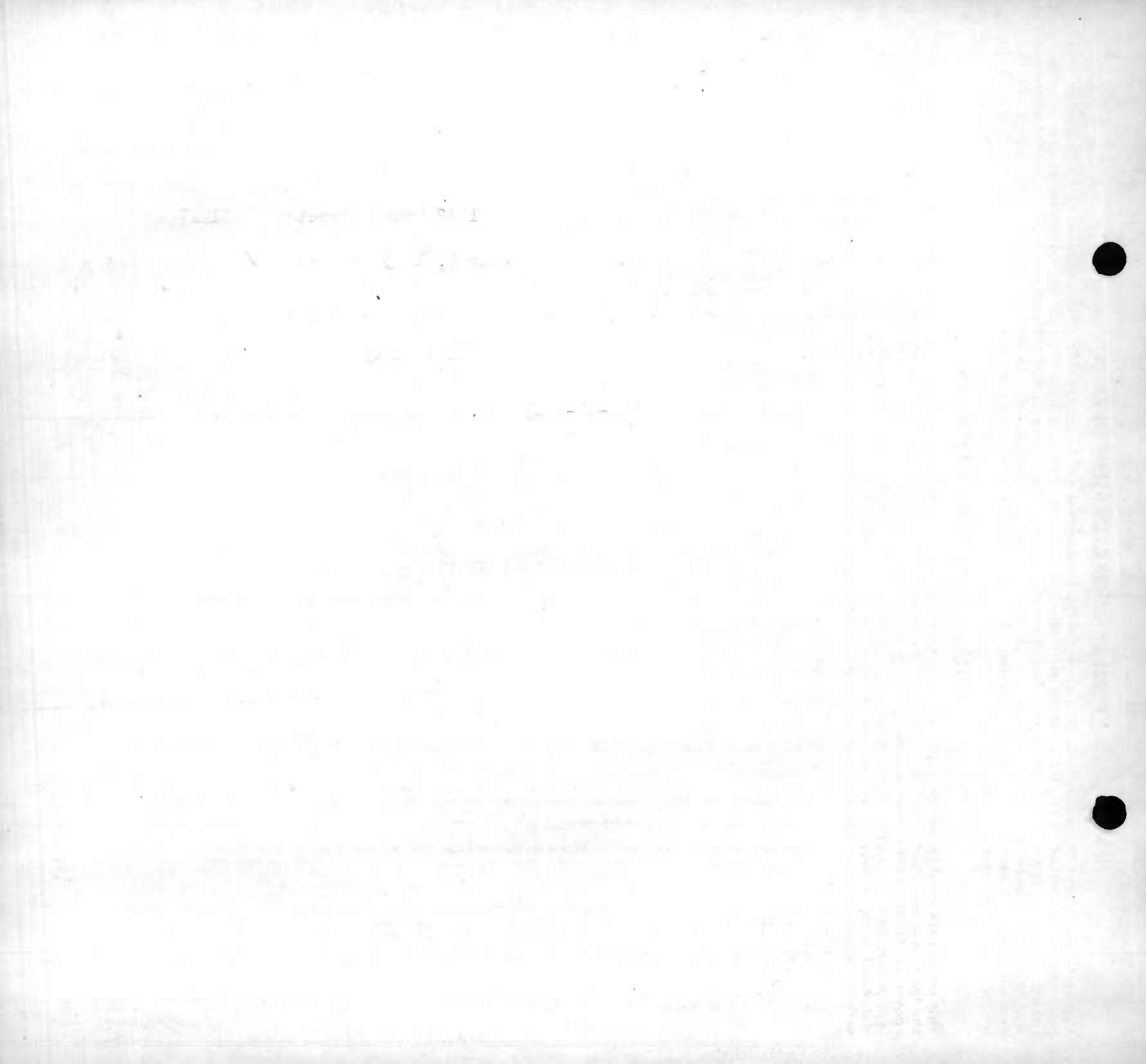
BIRTH NO. 65 6397				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6397	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
George J. Simon, Sr.				6-17-65			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
St. Agnes Hospital				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				3398 Dulany Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
Male	White	Married	6-9-20	45			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Truck Driver		Krill Co.		Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Walter A. Simon				Julia A. Davis			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes WWII						Mrs. Isabelle T. Simon-3398 Dulany St. 21229	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) ACUTE MYOCARDIAL INFARCTION DUE TO PERICARDIAL DAMAGE			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DIABETES MELLITUS DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/1/1958 to 6/17/1965, that (I) (we) lost saw the deceased alive on 6/17/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
John H. Shaw				6/18/65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
John H. Shaw				5800 Edmondson Avenue, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6-19-65		Loudon Park		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 21 1965		Robert E. Taylor		Howard H. Hubbard-4107 Wilkens Ave-21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 6398		CERTIFICATE OF DEATH		Registered No. 65 6398	
1. NAME OF DECEASED (Type or Print) <i>William Webb</i>				2. DATE AND HOUR OF DEATH <i>July 19 1965 June 2 30 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lincoln Memorial Nursing Home</i> <i>27 N. Carey Street</i> <i>Baltimore, Md. 21229</i>				A. STATE <i>MARYLAND</i>		B. COUNTY <i>14-03</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		D. STREET ADDRESS (If rural, give location) <i>1832 Brunt Street</i>		<i>21217</i>	
5. SEX <i>M</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>July 5, 1883</i>		9. AGE (In years (last birthday)) <i>82</i>		Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lamp Lighter</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>American Street Lighting Company</i>			11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Richard Webb</i>			14. MOTHER'S MAIDEN NAME <i>Ella Carey</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>214-14-5813</i>		17. INFORMANT <i>Mr. Frank Webb</i>		ADDRESS <i>801 Homestead St. Baltimore, Maryland</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <i>Chronic Uremia</i> (A) DUE TO <i>adenocarcinoma of</i> (B) DUE TO <i>Prostate</i> (C) INTERVAL BETWEEN ONSET AND DEATH <i>?</i> <i>?</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>June 2 1965</i> to <i>June 19 1965</i> , that (I) (we) lost saw the deceased alive on <i>June 18 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>W. R. Johnson</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>						23B. DATE SIGNED <i>6-19-65</i>			
23C. PHYSICIAN'S NAME (Type) <i>W. R. Johnson</i>						23D. ADDRESS <i>4037 Medart Bldg</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/21/1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 21 1965</i>			25B. NAME OF REGISTRAR <i>Robert E. Farkley</i>		25C. FUNERAL DIRECTOR <i>Wm. J. Johnson + Sons</i>		ADDRESS <i>Bldg. 21217</i>		



BIRTH NO.

65 6399

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 6399

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Donald Howard

2. DATE AND HOUR PRONOUNCED DEAD

June 6, 1965

5:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

U.S.S. Chinook, Pier 4, Pratt Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

MAY 6, 1935

9. AGE (In years
last birthday)

30

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Sailor, UNITED STATES COAST GUARD

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Portsmouth, Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

LIONEL A HOWARD

14. MOTHER'S MAIDEN NAME

MARIE MOWERY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

YES

unknown
ACTIVE DUTY16. SOCIAL
SECURITY NO.

720-30-1760

17. INFORMANT

ADDRESS

USCG records, Curtis Bay, Maryland

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

A.A. County, Rt. 2 and Charles Road

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

June 6 1965 5:10A

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

auto-fixed object collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 6, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9 June 1965

23C. NAME of CEMETERY or CREMATORY

BALTIMORE NATIONAL CEMETERY, BALTIMORE, MARYLAND

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 21 1965

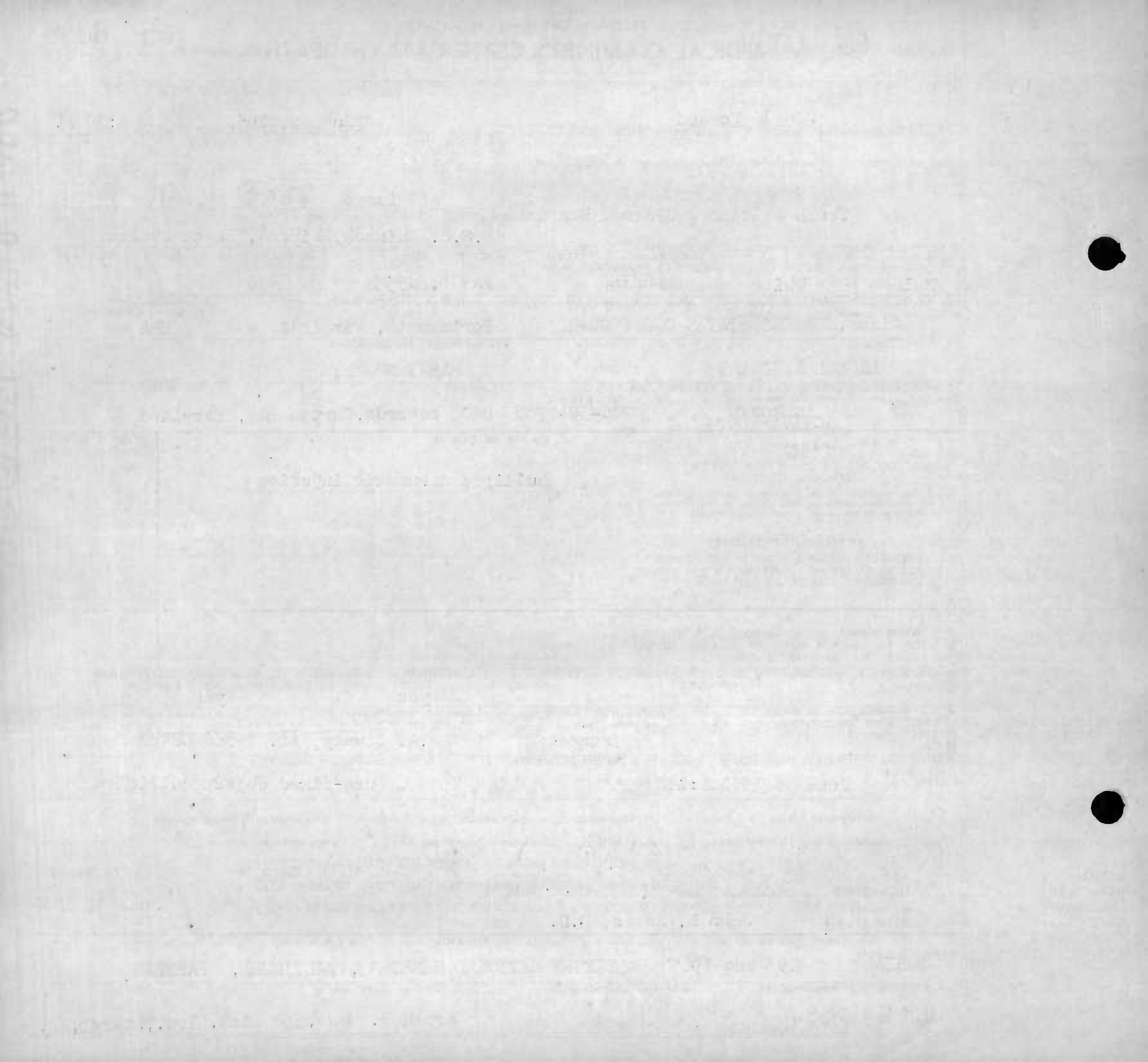
24B. NAME OF REGISTRAR

Robert E. Farkas, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

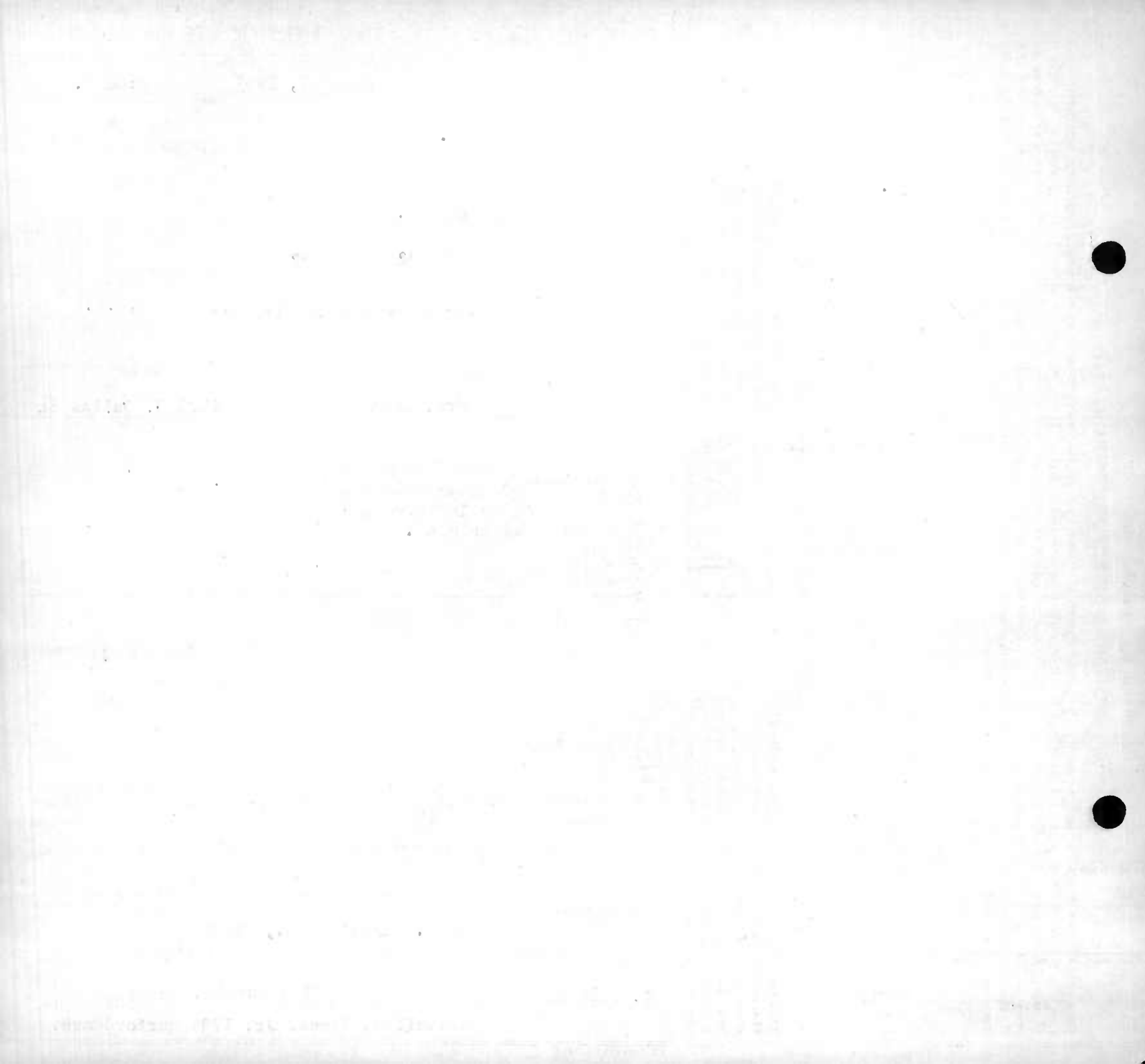
Harold S. Wade, 550 Wash. Blvd., Laurel, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

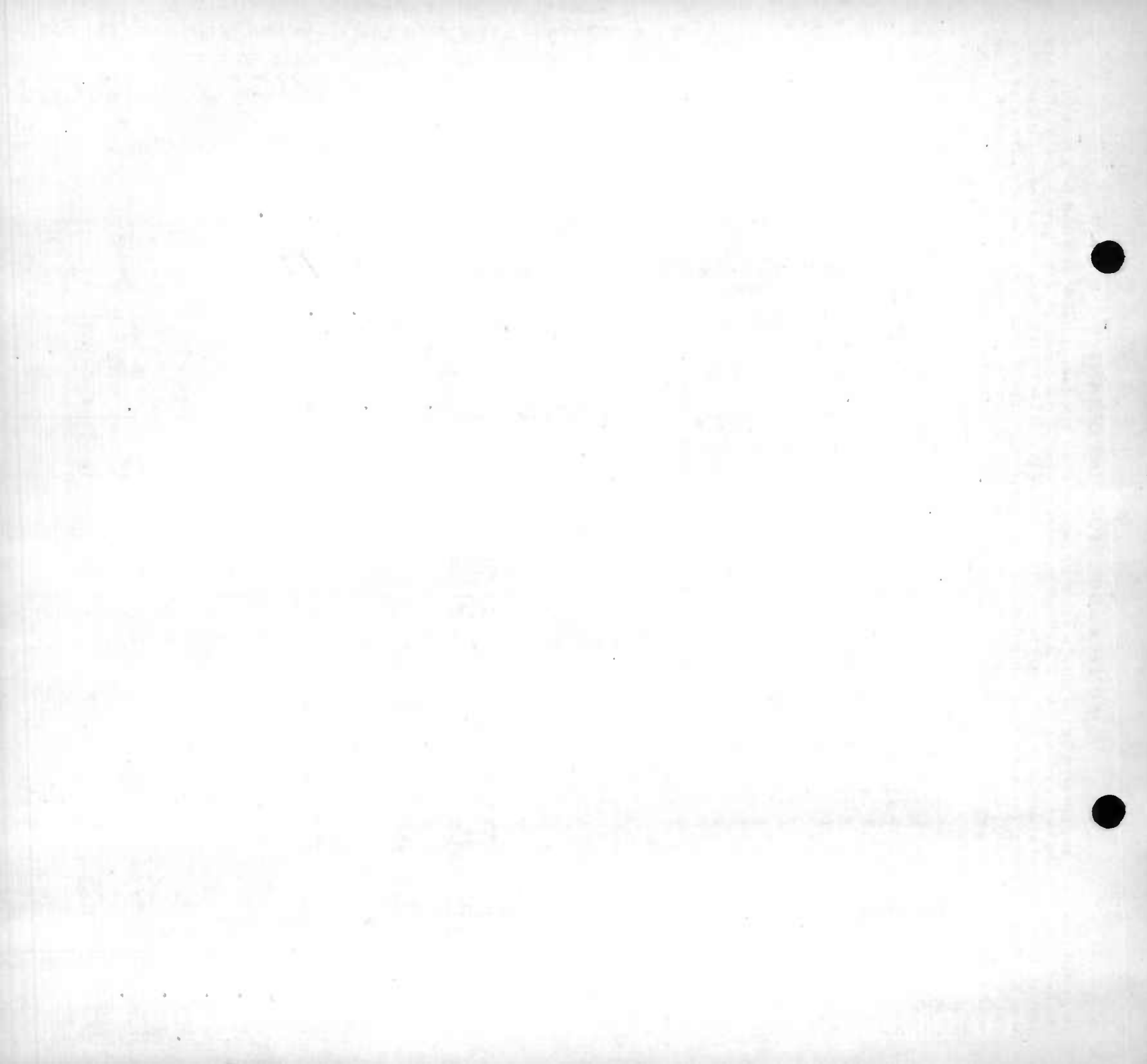
BIRTH NO. 65 6400		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 6400	
1. NAME OF DECEASED (Type or Print) HILL, JOHN S.			2. DATE AND HOUR OF DEATH June 17, 1965 6:04 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 8-06 B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 13 D. STREET ADDRESS (If rural, give location) 1524 N. Dallas		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/31/02	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY LABOR		11. BIRTHPLACE (State or foreign country) King & Queen Co., Virginia	
13. FATHER'S NAME UNKNOWN			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. M.D.		17. INFORMANT ADDRESS Mrs. Reba Hill (Wife) 1523 N. Dallas St
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH Rupture of congenital aneurysm of anterior communicating artery into left frontal lobe and ventricles.		
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from June 17 19 65 to June 17 19 65, that (I) (we) lost saw the deceased alive on June 17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William B. Vandegrift				23B. DATE SIGNED June 18, 1965	
23C. PHYSICIAN'S NAME (Type) William B. Vandegrift				23D. ADDRESS M.D. 1400 N. Caroline St., 21213	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6-21-65	24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Marshall W. Jones, Jr. 1735 Harford Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

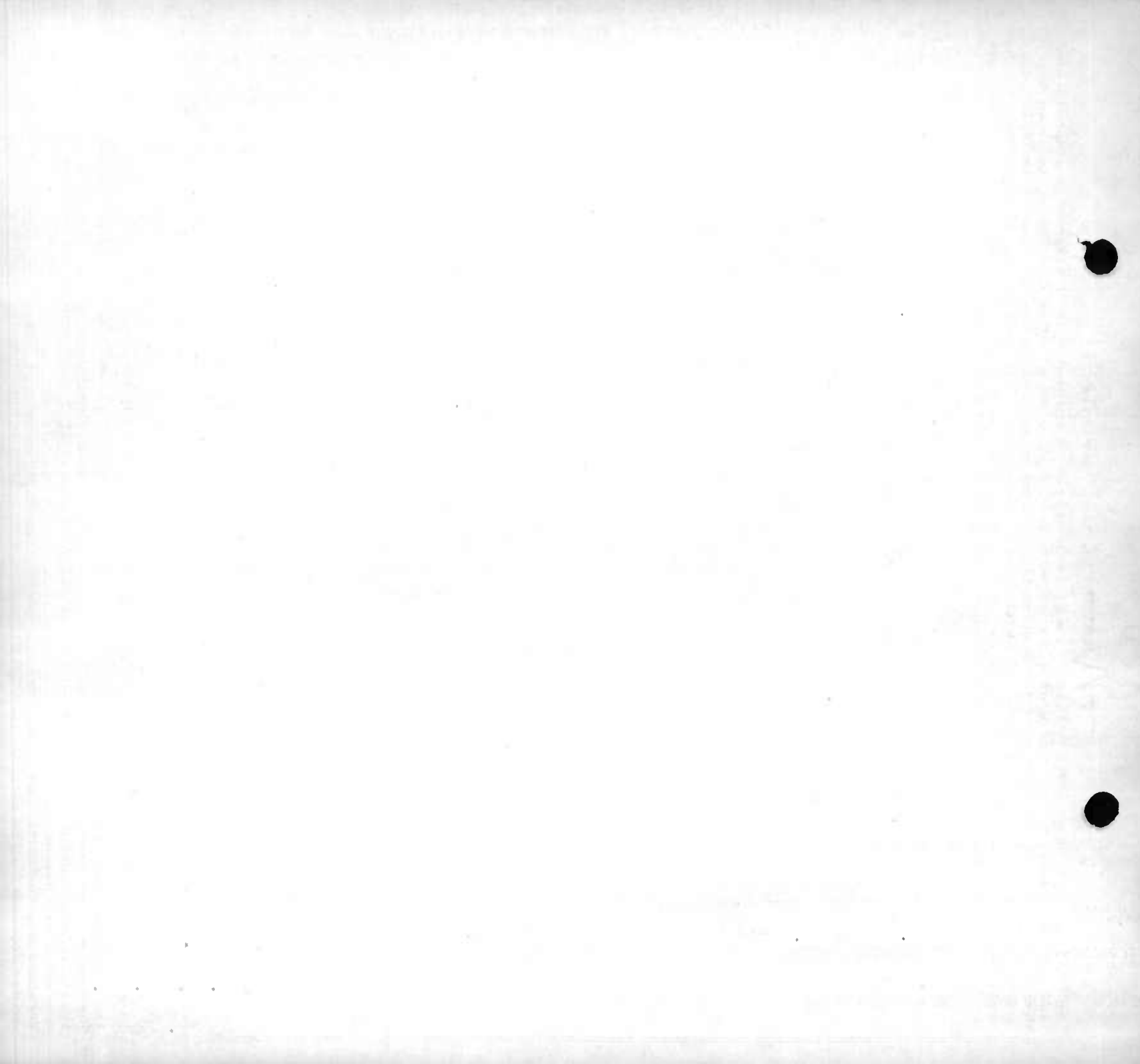
BIRTH NO. 65 6401				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6401	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Knapp, Margaret</i>				2. DATE AND HOUR OF DEATH <i>18 Jun 65</i> <i>2 31 P</i> M.			
3. PLACE OF DEATH IN BALTIMORE/MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Fayette Convalescent Home</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY <i>24-04</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>1726 Jackson St.</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>(unk) Widow</i>	8. DATE OF BIRTH <i>3 Jan 1886</i>	9. AGE (In years last birthday) <i>79 yrs</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Unknown Link</i>				14. MOTHER'S MAIDEN NAME <i>Unknown Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-34-6915</i>		17. INFORMANT <i>Mrs. Benj. Egan</i>		ADDRESS <i>1726 Belt St.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>491X-191.1</i> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) <i>Branchopneumonia</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>CVA & homiplegia Basal Cell Ca. (rt. lower lid)</i>						<i>preadmission several yrs</i>	
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Oct 19 61</i> to <i>18 Jun 19 65</i> , that (I) (we) lost saw the deceased alive on <i>18 Jun 19 65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>J. Hulla</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>18 Jun 65</i>	
23C. PHYSICIAN'S NAME (Type) <i>J. Hulla</i>				23D. ADDRESS <i>2214 E Fayette St 21231</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6 19 65</i>		24C. NAME of CEMETERY or CREMATORY <i>Cedar Hill</i>		24D. LOCATION (City, town, or county) (State) <i>Brooklyn, A. A. Co. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 21 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>Mc Gully</i>		ADDRESS <i>130 E. Fort Ave</i>	



FUNERAL DIRECTOR: IMPORTANT

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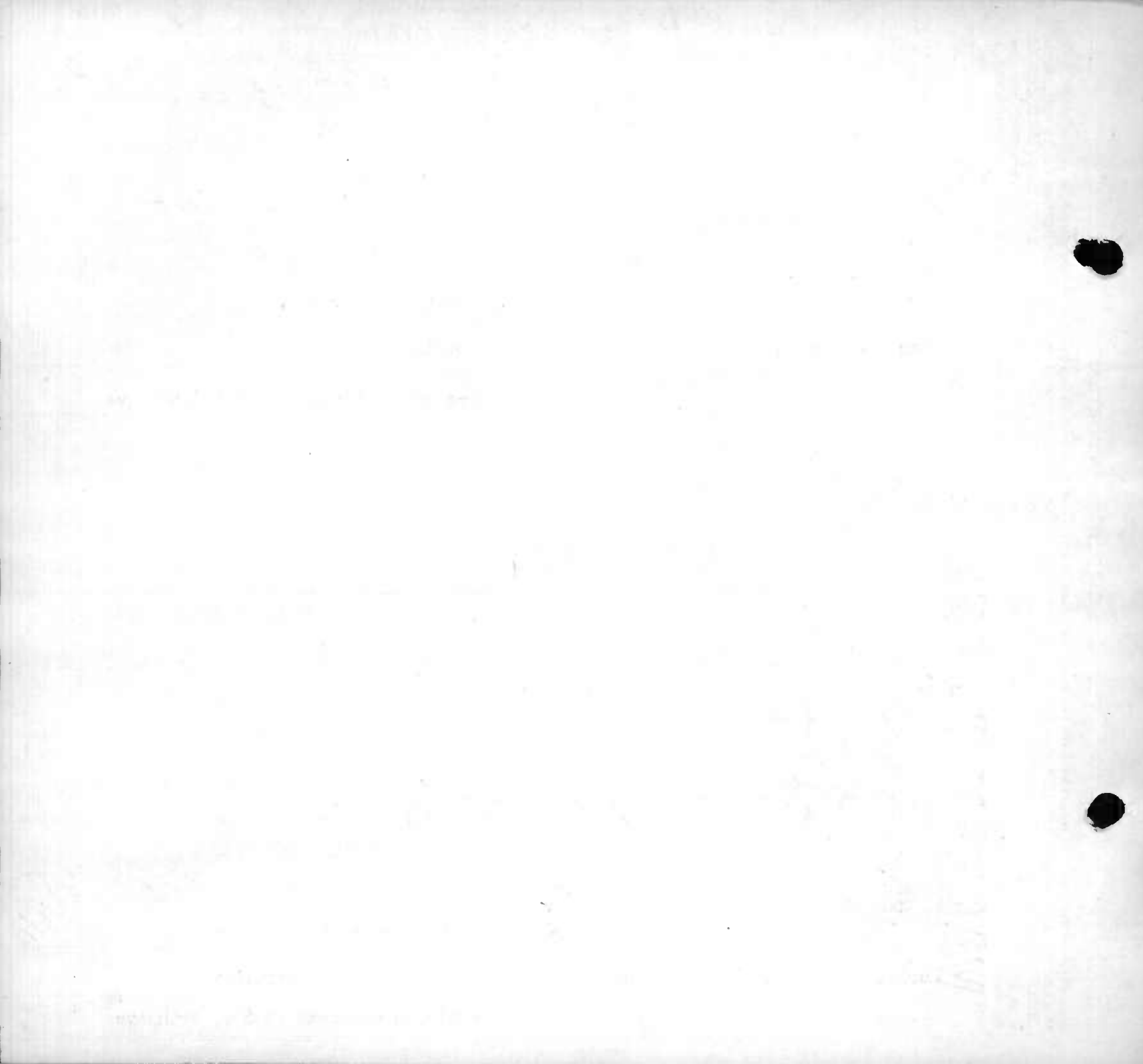
BIRTH NO. 65 6402				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6402	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Frances F. Prince</i>				2. DATE AND HOUR OF DEATH <i>6-17-65</i> <i>5:15A.</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>9.9</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>South Baltimore General Hosp.</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Glen Burnie</i> <i>52-00</i>			
D. STREET ADDRESS (If rural, give location) <i>221 Juniper Dr.</i>				5. SEX <i>F</i> 6. RACE <i>White</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>			
8. DATE OF BIRTH <i>2-25-1894</i> 9. AGE (in years last birthday) <i>71</i>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> 11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>				13. FATHER'S NAME <i>Joseph Brash</i>			
14. MOTHER'S MAIDEN NAME <i>Mary Skula</i>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS <i>Mrs. Frances Markowski 221 Juniper Drive</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Anterioschotic Cardiovascular Disease</i>				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No.</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <i>6-17</i> 19 <i>65</i> to <i>6-17</i> 19 <i>65</i> , that (we) lost saw the deceased alive on <i>6-17</i> 19 <i>65</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Kermit P. Bonovich</i> M.D.				Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6-17-65</i>	
23C. PHYSICIAN'S NAME (Typo) <i>Dr. Kermit P. Bonovich</i>				23D. ADDRESS M.D. <i>South Baltimore General Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6 21 65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven</i>		24D. LOCATION (City, town, or county) (State) <i>Glen Burnie, A. A. Co. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 21 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Mc Cully</i>		ADDRESS <i>130 E. Fort Ave</i>	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 6403		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6403	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WILLIAMSON, LULA E.		2. DATE AND HOUR OF DEATH 6/17/65 6:25 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND. B. COUNTY 15-03			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MD		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 1701 THOMAS AVE.			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) N	8. DATE OF BIRTH 8/28/99	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Mac Jones		14. MOTHER'S MAIDEN NAME Louella		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Anna Stevens 1701 Thomas Ave	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DIABETIC ACIDOSIS DUE TO (B) C.V.A. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/11/65 to 6/17/65, that (I) (we) last saw the deceased alive on 6/17/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joon Sueck Lee		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/17/65	
23C. PHYSICIAN'S NAME (Type) JOON SUECK LEE		23D. ADDRESS LUTHERAN HOSP; OF MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/22/65		24C. NAME OF CEMETERY or CREMATORY Dunn	
24D. LOCATION North Carolina		25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave			
25D. ADDRESS					



BIRTH NO. 65 6404 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
MILDRED (BASCHAL) PASCHALL		6/18/65 2:30 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
University Hospital		Maryland 17-02	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Baltimore	
		D. STREET ADDRESS (If rural, give location)	
		518 W. Preston St.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
female	colored	Separated	Oct. 19, 1925
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday)
Domestic			39
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Virginia			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Foster Hughes		Anna Hughes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
			Brenda Howard 518 W. Preston St.

MEDICAL CERTIFICATION	18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
	19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
	21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
	ACTUAL SIGNATURE <u>Werner U. Spitz</u> EXAMINER'S NAME (Type) <u>Werner U. Spitz, M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6/18/65</u>	
	23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	23C. NAME of CEMETERY or CREMATORY
Burial		21 June 65	Mt Calvary Cemetery	Ann Arundel Cty., Md.
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS	
JUN 21 1965		Robert E. Farley	A. Halstead 1206 W. North Ave.	

WALLINGTON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6405 X				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6405	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Charles J Girard</i>		2. DATE AND HOUR OF DEATH 6-17-65 6:50P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY <i>Balto</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE <i>Middle River</i> D. STREET ADDRESS (If rural, give location) 1125 BEECH DRIVE <i>5300</i>			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12-21-10	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Martins (Retired)</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Ogdensburg, N. Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME FRANK			14. MOTHER'S MAIDEN NAME ROSE SYRES				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>108-18-2024</i>		17. INFORMANT <i>Wife (Same as above)</i>		
18. 200.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Intestinal Perforation ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. RETICULUM CELL SARCOMA II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH Intestinal Perforation Reticulum Cell SARCOMA		INTERVAL BETWEEN ONSET AND DEATH 1 da. 1 yr.		
19A. DATE OF OPERATION 6/17/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Perforation		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 6/15/1965 to 6/17/1965 , that (we) last saw the deceased alive on 6/17/1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Samuel E. Omerly Jr.</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/17/65	
23C. PHYSICIAN'S NAME (Type) Samuel E. Omerly Jr.				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/21/65		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Balto., Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>Connolly, 300 Mace Ave. Balto. 21</i>		ADDRESS	

1944

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6406	
BIRTH NO. 65 6406		X		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Fields, Susie SIMMONS		2. DATE AND HOUR OF DEATH 6-17-65 5:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Balto		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Md. 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL		D. STREET ADDRESS (If rural, give location) 639 Sterling Ave.			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 2-4-07	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Amstead Jett		14. MOTHER'S MAIDEN NAME Mary Eberhart		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Franklin Fields 3041 Belmont Ave	
18. 432X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Septicemia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Bacterial Pericarditis		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Hypertensive encephalopathy					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-9 1965 to 6-17 1965 , that (I) (we) last saw the deceased alive on 6-17 1965 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Paul J. Edgar				23B. DATE SIGNED 6/19/65	
23C. PHYSICIAN'S NAME (Typed) Paul J. Edgar				23D. ADDRESS Mercy Hospital Baltimore Md.	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/21/65		24C. NAME OF CEMETERY or CREMATORY Mt Calvary	
24D. LOCATION Baltimore Maryland		24E. NAME OF REGISTRAR Robert E. Taylor		24F. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

13-21

20f HCCN

Basal for use

Chemical hypodermic

yes

2-10 15-10 10-10

Paul J. Edgar

Paul J. Edgar

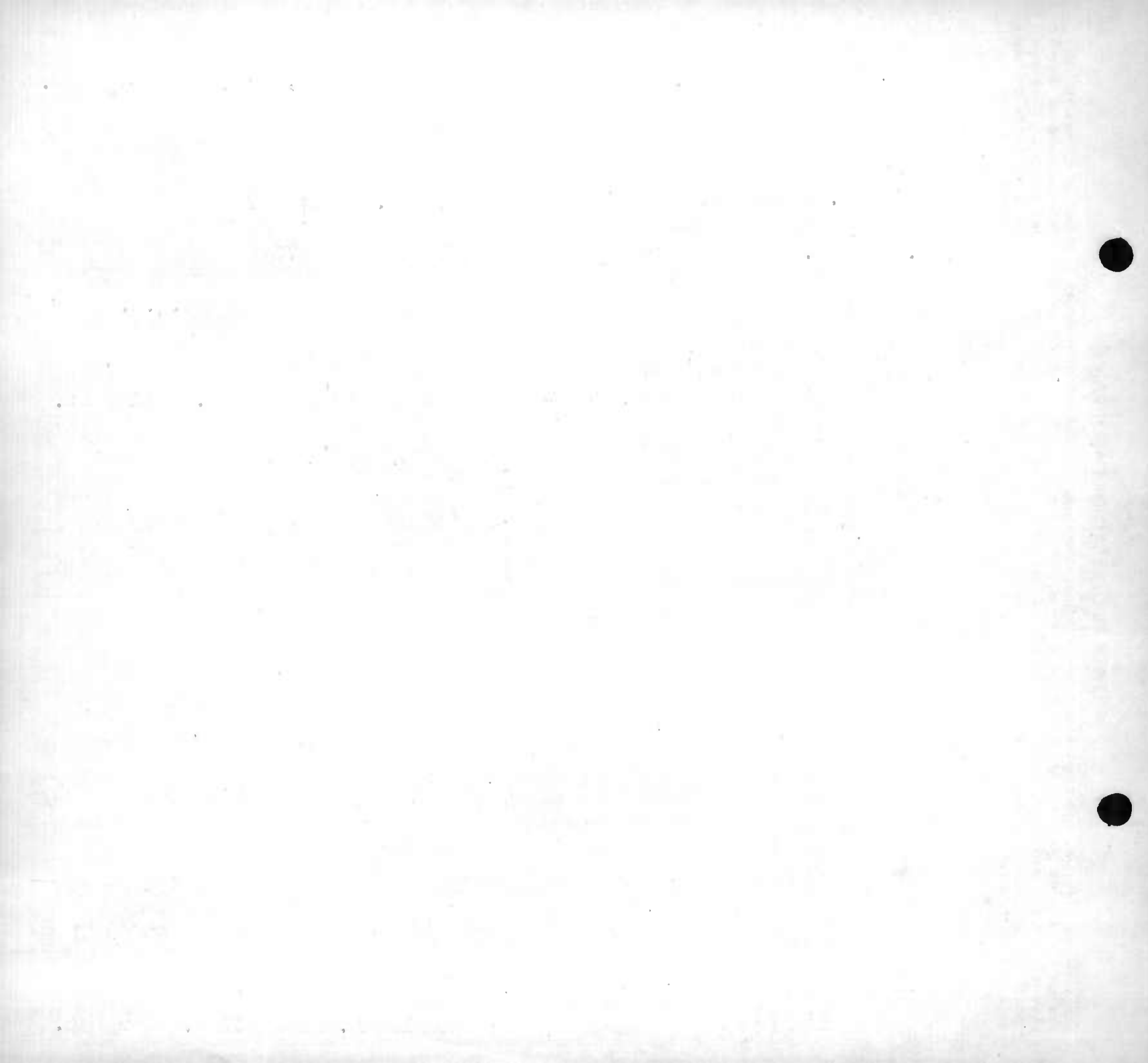
Wash. State

1/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6407		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6407	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) George E. Graves		
2. DATE AND HOUR OF DEATH June 20, 1965 6:15 A.M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 514 Mt. Holley St		
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 20-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 514 Mt. Holley St			5. SEX M. 6. RACE C. 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		
8. DATE OF BIRTH 4/15/1892 9. AGE (In years lost birthday) 73			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME David Graves			14. MOTHER'S MAIDEN NAME Katherine		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 126-03-2287		
17. INFORMANT ADDRESS Phoebe Graves 514 Mt. Holley St.			18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from June 19, 1965 to June 20, 1965, that (I) (we) last saw the deceased alive on June 19, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. B. Rofsky			23B. DATE SIGNED 6-21-65		
23C. PHYSICIAN'S NAME (Type) S. B. Rofsky			23D. ADDRESS 601 N. Howard St. Baltimore		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/23/65		24C. NAME OF CEMETERY OR CREMATORY Baltimore National	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR Charles A. Rice		25D. ADDRESS 661 W. Barre St.			

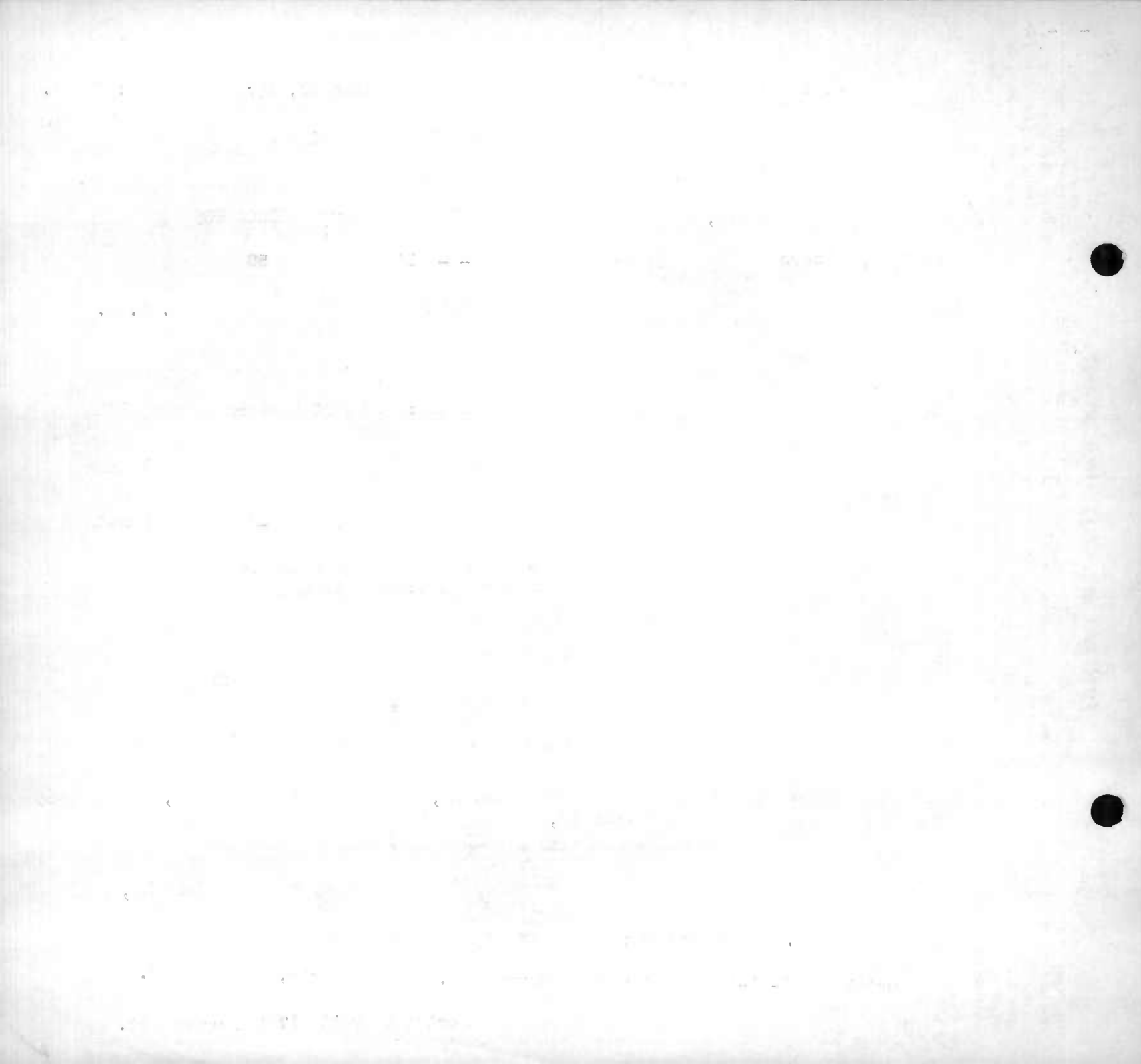


43-87-14
FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6408			
BIRTH NO. 65 6408				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Jake Cole (Jacob)				June 17, 1965 11:30 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland B. COUNTY Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Texas			
				D. STREET ADDRESS (If rural, give location) Railroad Avenue 21204 605			
5. SEX Male		6. RACE Negro		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 7-7-1914	
						9. AGE (In years last birthday) 50	
						If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Alabama	
13. FATHER'S NAME UNK				14. MOTHER'S MAIDEN NAME UNK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 331X I				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) Pneumonia DUE TO			
				(B) Cerebral Vascular Accident-Coma DUE TO			
				(C) Hypertensive Arteriosclerotic Cerebral Vascular Disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH ? 1 Week			
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 14, 19 65 to June 17, 19 65 , that (I) (we) last saw the deceased alive on June 17, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Howard Rathbun						23B. DATE SIGNED June 17, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Howard Rathbun						23D. ADDRESS 4940 Eastern Avenue 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-21-65		24C. NAME OF CEMETERY or CREMATORY Stevenson Church Cem.		24D. LOCATION (City, town, or county) (State) Sparks, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Morton & Dyett		ADDRESS 1701 Laurens St.	



BIRTH NO.

65

6409

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES L. JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

June 16, 1965

10:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1122 Shields Place

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

17-02

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1122 Shields Place

5. SEX

Male

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Aug 30 - 1904

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore - Maryland N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

William W. Adams

14. MOTHER'S MAIDEN NAME

Nannie W. Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-01-5118

17. INFORMANT

Luther Adams

ADDRESS

1122 Shields Place

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Bronchial asthma
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic cardiovascular disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-16-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-18-65

23C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

B.A. County, Md

24A. DATE REC'D BY HEALTH DEPT.

JUN 21 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Morton + Dyett Funeral Home Inc

ADDRESS

WALLACE FORBES

PAID 10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6410		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6410	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
LEWIS, BABY GIRL		6-18-65		8:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MD.		B. COUNTY 16-08	
ST AGNES HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
		D. STREET ADDRESS (If rural, give location)		1200 WILDWOOD PARKWAY 21229	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FEMALE	NEGRO	NEVER MARRIED	6-18-65		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
			MARYLAND	U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
FOSTER		ROSABELL GRAVES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				AVES. 21229	
				ST AGNES HOSPITAL, WILKINS AND CATON	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Prematurity		Less than 39 minutes	
ANTECEDENT CAUSES		(B) Premature rupture of membranes		After birth	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6-18-19 65 to 6-18-19 65, that (I) (we) last saw the deceased alive on 6-18-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Philip Whelen				6/18/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
PHILIP WHELEN MD		ST AGNES HOSPITAL CATON & WILKINS AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		6-19-65		Mt. Auburn Cem.	
24D. LOCATION (City, town, or county)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
Balt. Md.		Morton & Dyett		Funeral Home	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 21 1965		Robert E. Fisher, M.D.		Morton & Dyett	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Philip W. MAIER				2. DATE AND HOUR PRONOUNCED DEAD 6/18/65 10:45 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) City Hospitals				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6809 Fait Ave.			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH Feb-II, 1947	9. AGE (In years last birthday) 18	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attended school				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore.	
13. FATHER'S NAME Philip W. Maier				14. MOTHER'S MAIDEN NAME Mary Cutean			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no		17. INFORMANT ADDRESS Philip W, Maier 6809 Fait Ave	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) Craniocerebral injury DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) German Hill Rd. and Delbert Ave.			
21D. TIME OF INJURY (APPROX.) 6 18 65 9:45p.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? passenger in auto which struck pole			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				DATE SIGNED 6/19/65			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6-23-65		23C. NAME of CEMETERY or CREMATORY Oaklawn Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR ADDRESS Walter Dabrowski 1005 Dundalk Ave.			

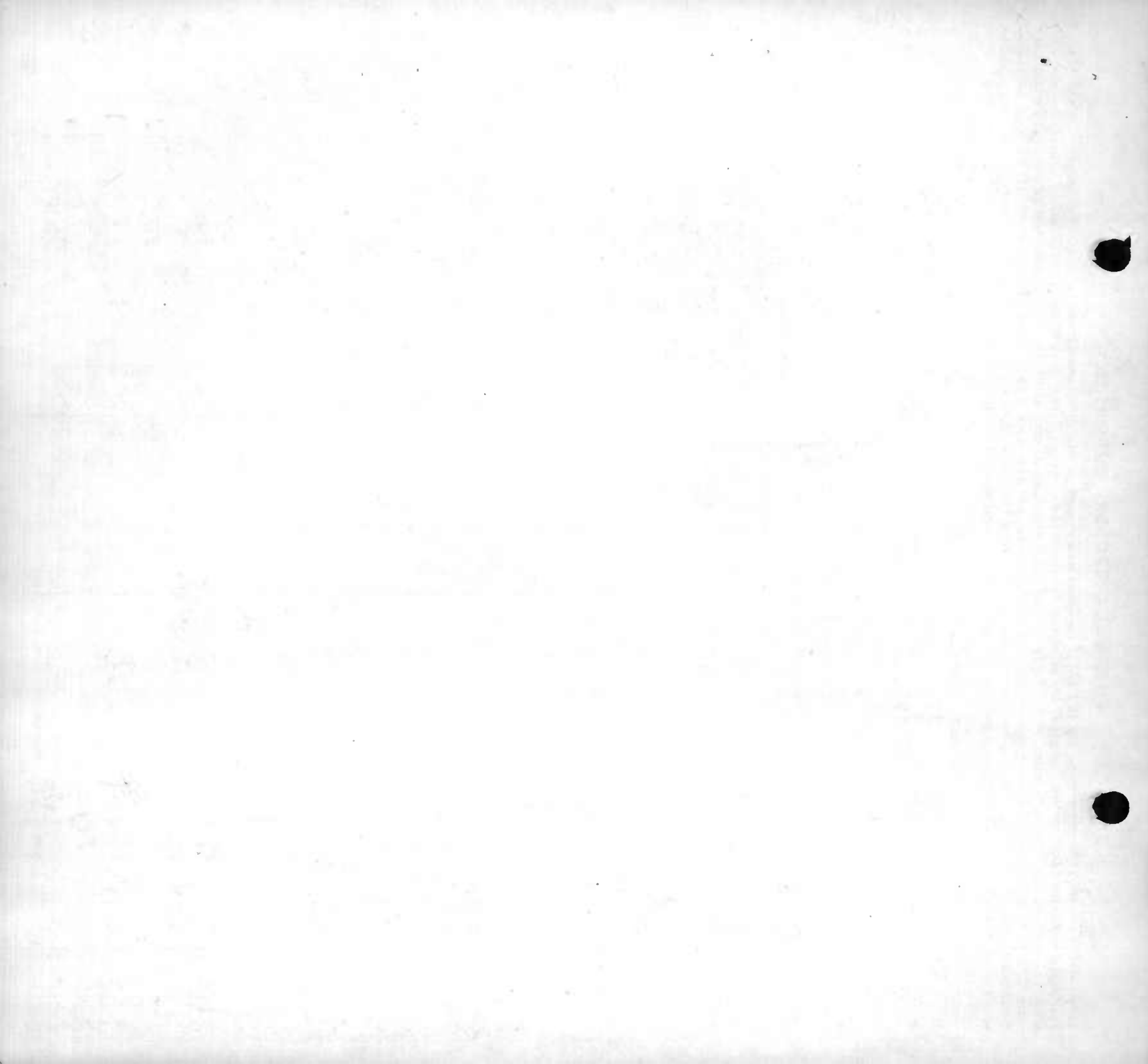
WALLACE ROBERTS
D.D. 1871

1871

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

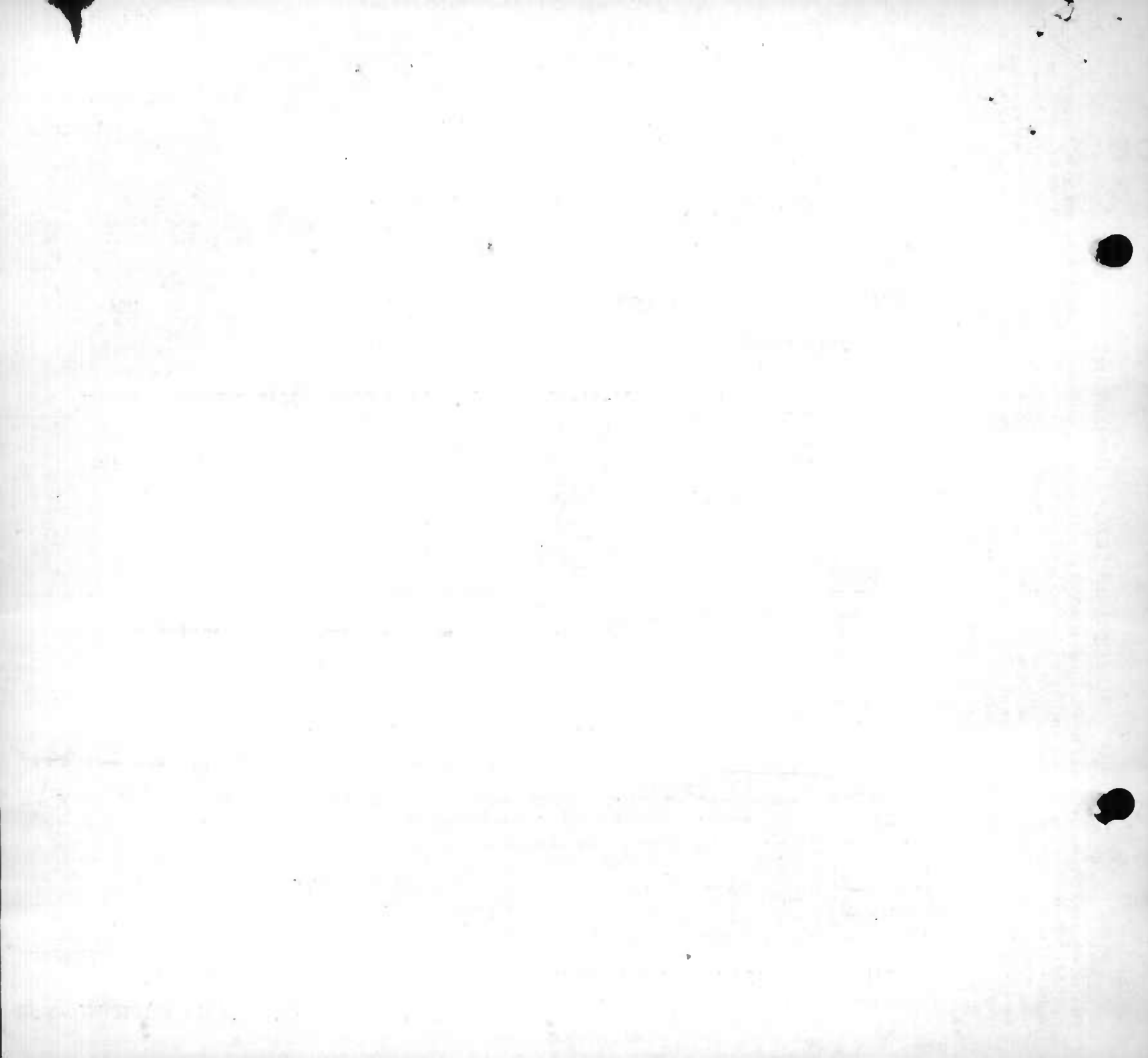
BIRTH NO. 65 6412				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6412	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Samuel Kostin		June 15, 1965 3:15 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
3600 Holgrinth Road				Maryland			
apt H-21 Green Acres Ct apt				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
D. STREET ADDRESS (If rural, give location)				3600 Holgrinth Rd apt H-21			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Male	White	WIDOWED, DIVORCED (specify)	3-11-1898	75	Sales Rep. Bottles + Jars	New York City	USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Morris Kostin				Molhe?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No						Mrs. Edna Kostin 3600 Holgrinth Rd	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1960 to 6/15/65, that (I) (we) last saw the deceased alive on 5/15/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Leonard M. Lister M.D.				6/15/65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Leonard M. Lister				7121 Park Heights Ave Baltimore, Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/17/65		Chzyak Amuro		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 21 1965		Robert E. Finkler, M.D.		Sal Lennion & Son - 6010 Reister Road			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

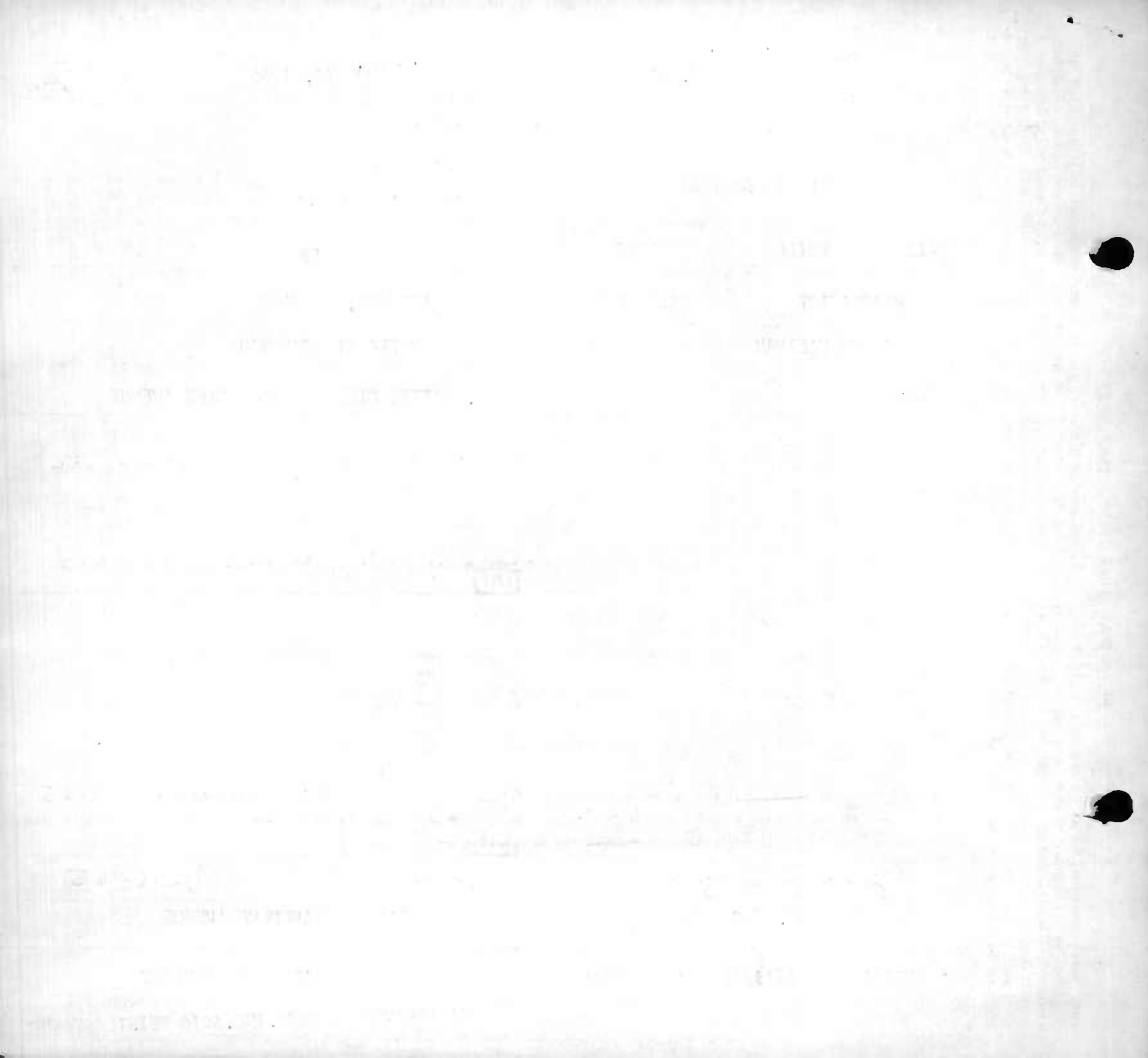
BIRTH NO. 65 6413				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6413	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ABRAHAM COHEN				2. DATE AND HOUR OF DEATH 6-16-65 6:20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND				A. STATE MARYLAND 15-09			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 3002 CHELSEA TERR			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 6-15-76	9. AGE (In years last birthday) 76	10. Under 1 Yr. Months Days 10. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10B. KIND OF BUSINESS OR INDUSTRY C LOTHING		11. BIRTHPLACE (State foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DAVID COHEN				14. MOTHER'S MAIDEN NAME SARAH ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-01-3297		17. INFORMANT ADDRESS MRS. HELEN COHEN 3002 CHELSEA TERRACE			
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. RESTORE OF APT. B.I.B.				CAUSE OF DEATH ACUTE PULMONARY EDEMA HYPERTENSIVE + ARTEROSCLEROTIC CARDIO VASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Hospital			
21D. TIME OF INJURY (APPROX.) 6-14-65		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? fell while getting out of bed.			
22. I certify that (I) (this hospital) attended the deceased from 6-7-65 to 6-16-65, that (I) (we) last saw the deceased alive on 6-16-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jesus G. Santiano M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-16-65	
23C. PHYSICIAN'S NAME (Type) JESUS G. SANTIANO M.D.				23D. ADDRESS LUTHERAN HOSP. OF Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/17/65		24C. NAME OF CEMETERY or CREMATORY ANSHE NESSINA		24D. LOCATION (City, town, or county) (State) ROSEDALE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR R. B. E. F. J. J.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6414				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 6414	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) IRVIN J. GLEIMAN		2. DATE AND HOUR OF DEATH JUNE 16, 1965		650 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		27-20	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL				D. STREET ADDRESS (If rural, give location) 4020 GLEN AVENUE					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHARMACIST		10B. KIND OF BUSINESS OR INDUSTRY DRUG STORE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME SIMON GLEIMAN				14. MOTHER'S MAIDEN NAME YETTA KIRSCHENBAUM					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. HATTIE GLEIMAN		ADDRESS 4020 GLEN AVENUE			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) <u>Acute Coronary</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
				(B) <u>Coronary artery disease</u> DUE TO		<u>10 years</u>			
				(C) <u>Coronary artery disease</u>					
MEDICAL CERTIFICATION				19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>1930</u> to <u>June 16</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>6-2</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				23A. SIGNATURE <u>Jack J. Singer</u> M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6-16-65</u>	
23C. PHYSICIAN'S NAME (Type) DR. JACK SINGER				23D. ADDRESS M.D. 1190 W BELVEDERE AVENUE					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/18/65		24C. NAME of CEMETERY or CREMATORY OHEB SHALOM		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.		ADDRESS 6010 REISTERSTOWN RD			



BIRTH NO. **65 6415** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **65 6415**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SAMUEL PROSTIC

2. DATE AND HOUR PRONOUNCED DEAD

June 16, 1965 11:55 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3201 Fait Avenue

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

9. AGE (In years
less day)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

GROCERY

10B. KIND OF BUSINESS OR INDUSTRY

RETAIL

11. BIRTHPLACE (State or foreign country)

POLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

HYMAN PROSTIC

14. MOTHER'S MAIDEN NAME

EVA RUCHSMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

217-32-8882

17. INFORMANT

ADDRESS

MRS. SOPHIE PROSTIC 3201 FAIT AVE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breiteneker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-17-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

6/18/65

23C. NAME of CEMETERY or CREMATORY

BNAI ISRAEL

23D. LOCATION

BALTIMORE

(City, town, or county)

MARYLAND

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 21 1965

24B. NAME OF REGISTRAR

Robert E. Fink

24C. FUNERAL DIRECTOR

SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD

ADDRESS

WALTON
M
P
O
R
G

WORLD
STATE
No 2

11-21-21
NEW SOUTH WESTERN
11-21-21

11-21-21
11-21-21

11-21-21

11-21-21

BIRTH NO.

65 6416

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 6416

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CLARE DAHLMAN

2. DATE AND HOUR PRONOUNCED DEAD

June 16, 1965

1:20 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

130 Slade Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

CINCINNATI OHIO

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

? BROWN

14. MOTHER'S MAIDEN NAME

PAULINE ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MR. MELVIN DAHLMAN 130 SLADE AVE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

6-15-65

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Head injury

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

Park Heights Ave. south of Shelbourne Rd.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6 15 65 9:00 P.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-16-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

6/17/65

23C. NAME of CEMETERY or CREMATORY

CHIZUK AMUNO

23D. LOCATION

BALTIMORE

(City, town, or county)

MARYLAND

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 21 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD

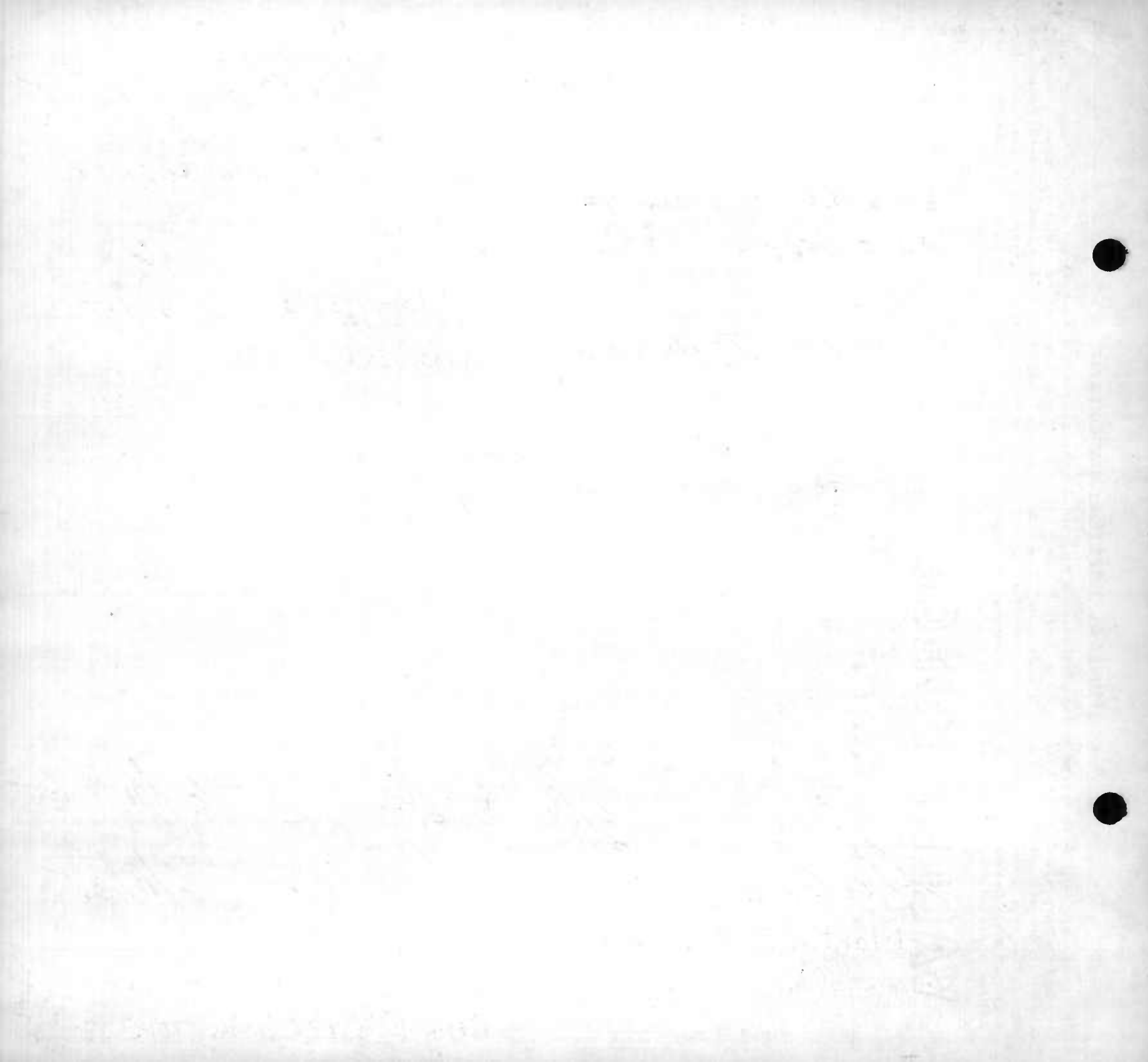
ADDRESS

WALLLEY HUGHES

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Baltimore City Health Department		Baltimore City Health Department	
BIRTH NO. <u>Crownsville, MD 65</u> 6417				CERTIFICATE OF DEATH		Registered No. <u>65</u> 6417	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) <u>BABY BOY JOHNSON</u>				<u>6/11/65</u>		<u>7:03 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE <u>Maryland</u>		B. COUNTY <u>AA</u>	
<u>UNIVERSITY HOSPITAL</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		<u>Crownsville State Hospital</u>	
				D. STREET ADDRESS (If rural, give location)		<u>52-00</u>	
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>6/5/65</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months: <u>6</u> Days: <u>6</u>	If Under 24 Hrs. Hours: <u>6</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES JOHNSON</u>				14. MOTHER'S MAIDEN NAME <u>None</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						<u>1624 Clifview Ave 21213</u>	
18. <u>768101</u>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) <u>MENINGITIS</u>			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				DUE TO			
ANTECEDENT CAUSES				(B) <u>SEPSIS</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				DUE TO			
(C)							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<u>6/11/65</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6/5/65</u> 19 <u>65</u> to <u>6/11/65</u> 19 <u>65</u> that (I) (we) last saw the deceased alive on <u>6/11/65</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Martin E. Zipser</u> M.D.				23B. DATE SIGNED <u>6/11/65</u>			
23C. PHYSICIAN'S NAME (Type) <u>Martin E. Zipser</u> M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Burial June 14/65 Int Calvary Cem. A.A.C. Rd</u>		<u>JUN 21 1965</u>		<u>Robert E. Fairley, M.D.</u>		<u>Robert Williams 1701-3rd Bond St</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<u>JUN 21 1965</u>		<u>Robert E. Fairley, M.D.</u>		<u>Robert Williams</u>		<u>1701-3rd Bond St</u>	



FUNERAL DIRECTOR: IMPORTANT

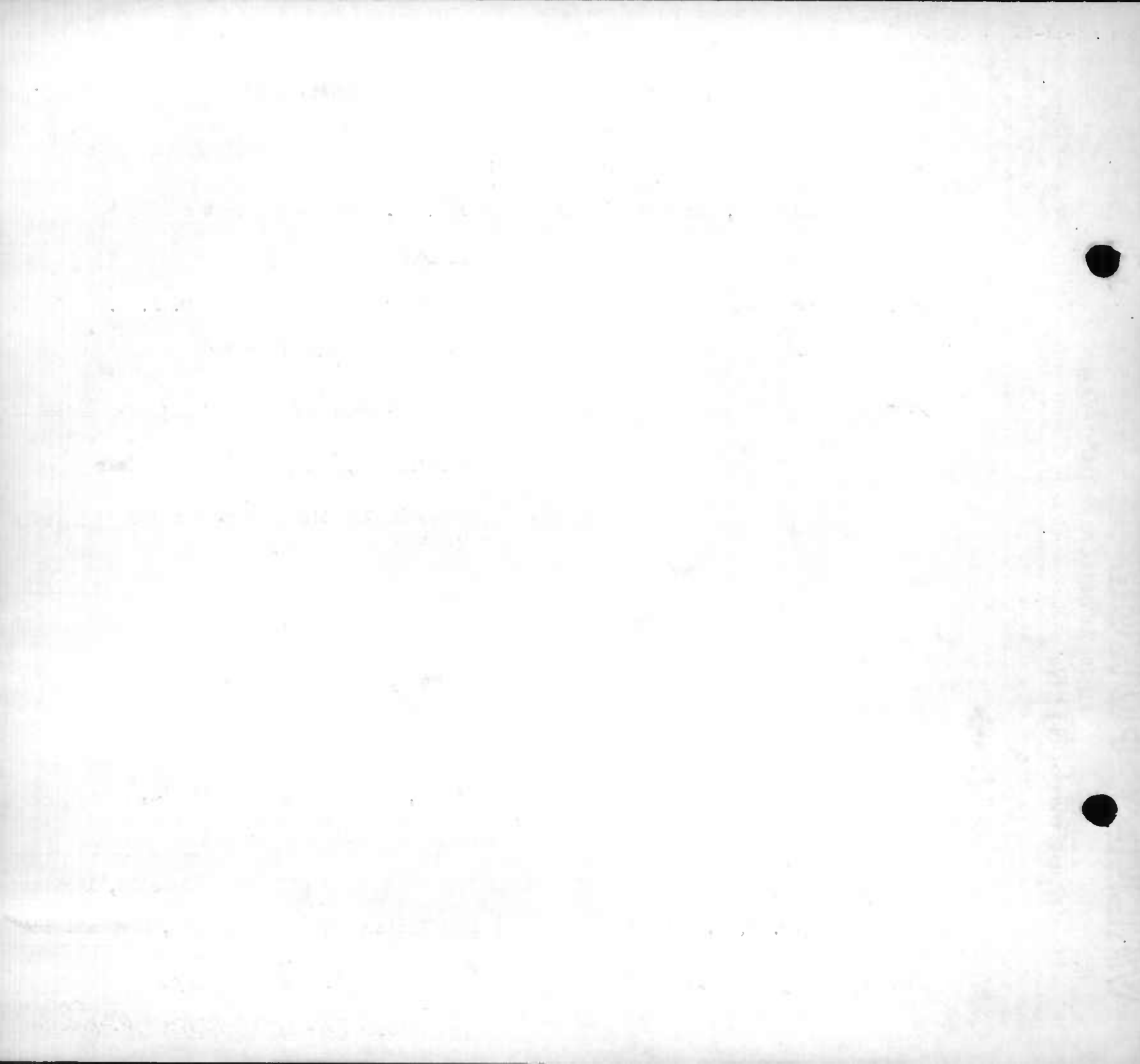
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 6418					CERTIFICATE OF DEATH					Registered No. 65 6418				
1. NAME OF DECEASED (Type or Print) CLAUDE SOUTHERS										2. DATE AND HOUR OF DEATH 6-17-65 2:30 PM				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY AA									
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY.					C. CITY OR TOWN (If outside city limits, write RURAL and give township) JESSUP 52-00									
					D. STREET ADDRESS (If rural, give location) Rt. #1 Box 244									
5. SEX M		6. RACE C		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) D		8. DATE OF BIRTH 4-14-95		9. AGE (In years last birthday) 70		If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) N. CAROLINA				
										12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME JONAS SOUTHERS										14. MOTHER'S MAIDEN NAME - ADDIE WILSON				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT PATIENT			ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PULMONARY HEMORRHAGE										INTERVAL BETWEEN ONSET AND DEATH 1 HR.				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. RIGHT UPPER LOBE CTOMY										2 mos				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION 16-17-65					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CO. LUNG					20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from 5-17 19 65 to 6-17 19 65 , that (1) (we) lost saw the deceased alive on 6-17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.														
23A. SIGNATURE N. W. Todd					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 6-17-65				
23C. PHYSICIAN'S NAME (Type) NEVINS W. TODD					M.D. 23D. ADDRESS - UNIVERSITY HOSPITAL									
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE June 22/65					24C. NAME of CEMETERY or CREMATORY Balto. National Cemetery				
										24D. LOCATION (City, town, or county) (State) Balto. City				
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965					25B. NAME OF REGISTRAR Robert E. Fairbank					25C. FUNERAL DIRECTOR Robert Williams				
										ADDRESS 1701-35 Grand St. N. 13th				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

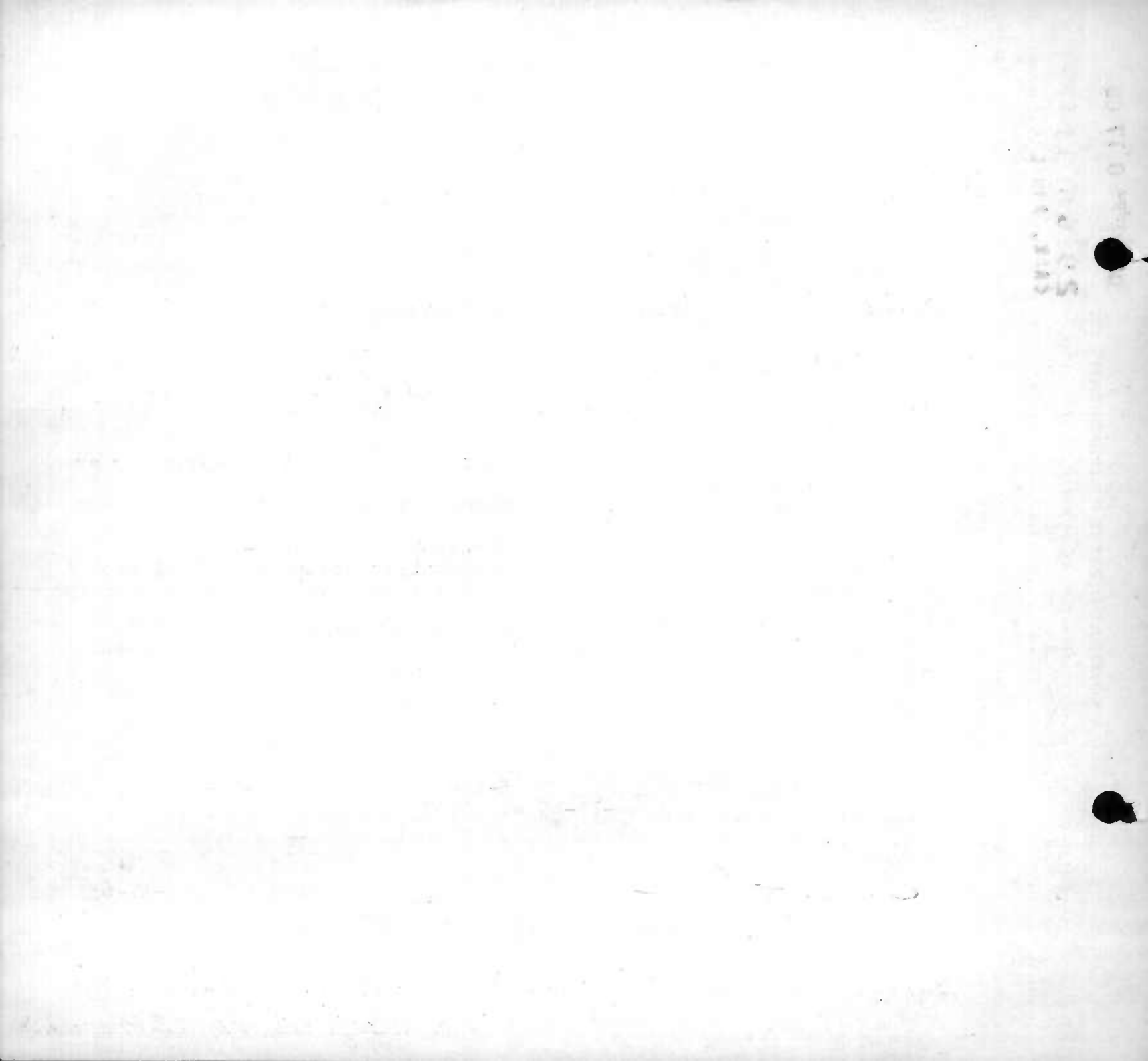
BIRTH NO. 7-575 6419		1. NAME OF DECEASED (Type or Print) Henry Thomas		2. DATE AND HOUR OF DEATH June 18, 1965 12:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 19-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1612 W. Lexington Street #21223			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 2-1-98	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Bessie Maryland	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 8, 1965 to June 18, 1965, that (I) (we) last saw the deceased alive on June 18, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. B. Zachary		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 18, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. J. B. Zachary		23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Maryland #24			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/22/1965		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION Balto. Md.		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Williams Funeral Home	
ADDRESS N. Schroeder St					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Underlying disease; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 6065 6420				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6420	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ANNIE LEE CARR				2. DATE AND HOUR OF DEATH 6-17-65 10:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 7-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 959 NORTH WOLFE STREET			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH 1-14-99	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10B. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Denwoodie Co. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ABRAHAM MILLER				14. MOTHER'S MAIDEN NAME MARY JEFFERSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-16-7335		17. INFORMANT FRANK CARR 959 N. Wolfe St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Generalized Bacterial Sepsis (B) Urinary Tract Infection (C) Infection of right B-K amputation stump		INTERVAL BETWEEN ONSET AND DEATH 3 ay 2 weeks 1 week	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus							
19A. DATE OF OPERATION 7		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-15-65 to 6-17-65, that (I) (we) last saw the deceased alive on 6-17-65 at 10:30 AM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE S. L. Johnson				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-17-65	
23C. PHYSICIAN'S NAME (Type) Steve L. Johnson				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-21-65		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Randolph Collick		ADDRESS 1412 E. Preston St.	



FUNERAL DIRECTOR: IMPORTANT

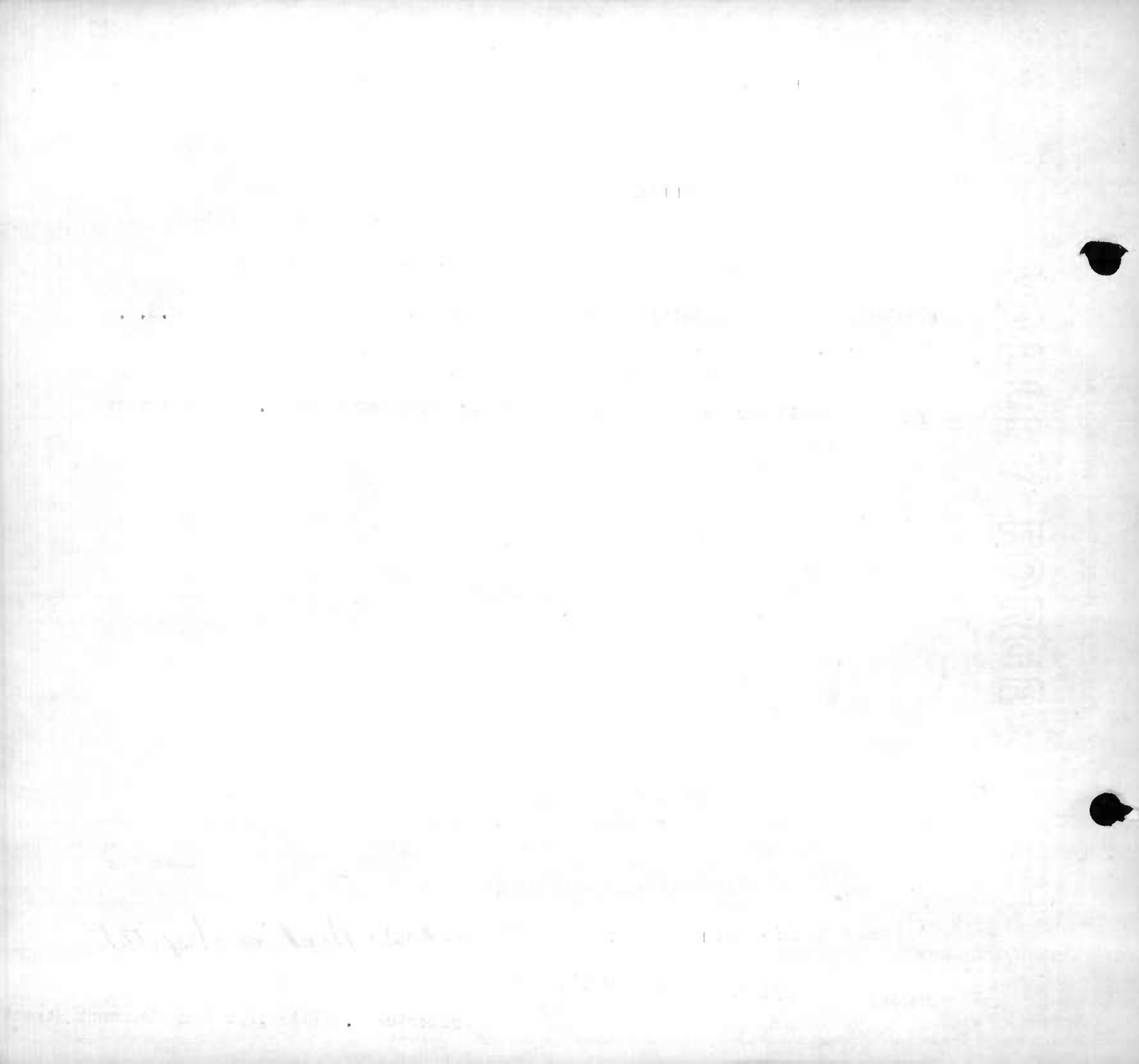
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B65965 6421		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6421	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
				BROWN, CLARA	
2. DATE AND HOUR OF DEATH		6/18/65 8:40 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Sinai Hospital		Maryland 7-05			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		1608 E. Monument St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
F	N	M	2/17/35	30	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Hospital Technician		Hospital		South Carolina	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Edd Smith		Viola Smalls		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Unknown		247-281455		Hospital Record	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) aplastic anemia		5 weeks	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		None Known			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/15/65 to 6/18/65, that (I) (we) last saw the deceased alive on 6/18/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Barnes M. Cohen				6/18/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Removal		6-22-65		Frost Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 21 1965		Robert E. Taylor		Randolph J. Collick 1412 E. Preston St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

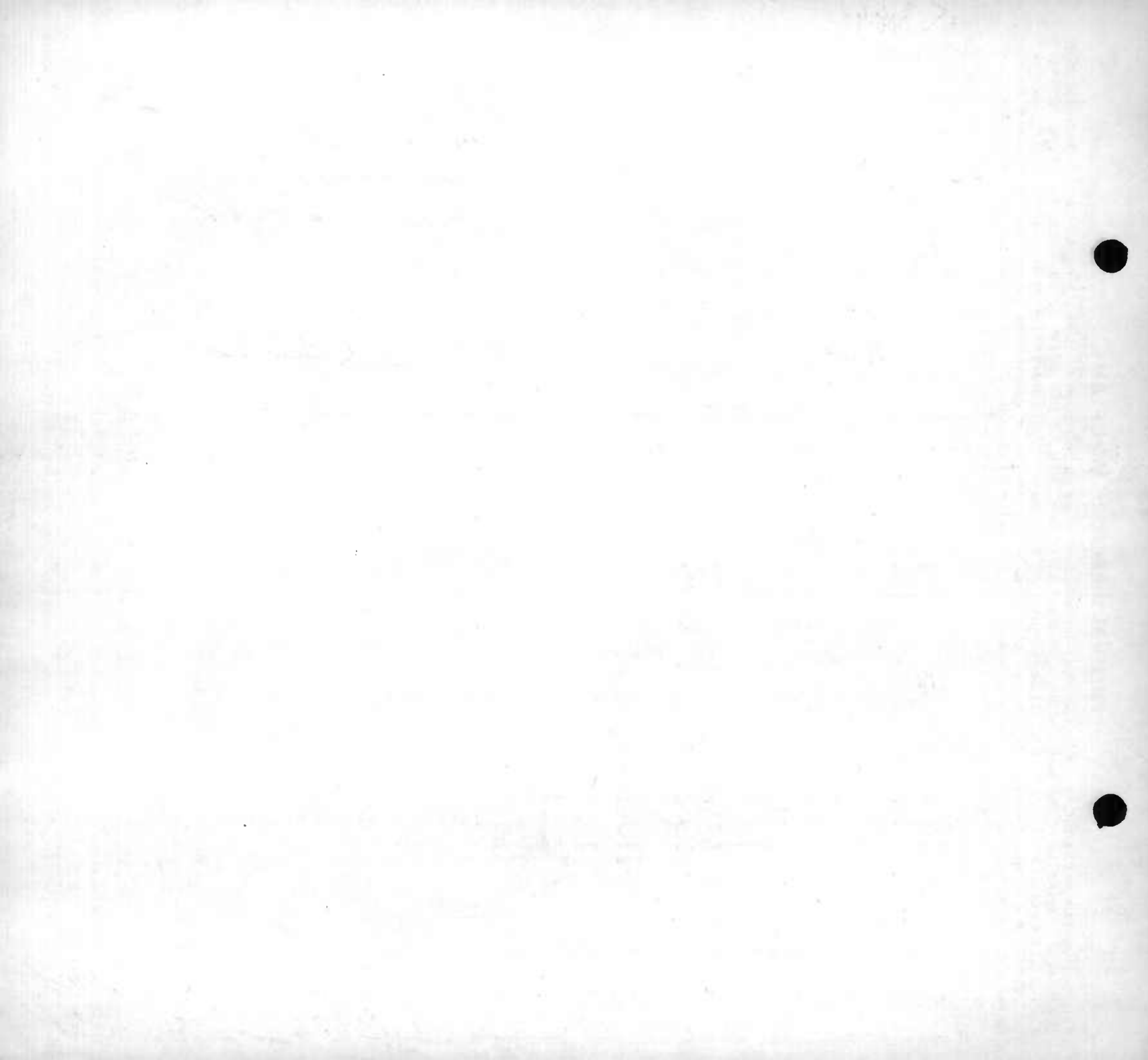
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6422	
BIRTH NO. 65 6422		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FRANCIS X. BURNS		2. DATE AND HOUR OF DEATH 6-18-65 1:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital at institution, give street address or location)		A. STATE B. COUNTY			
33 JOHNS HOPKINS HOSPITAL		MARYLAND			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		600 NORTH DECKER AVENUE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
MALE	WHITE	MARRIED	AUG. 19, 1920	44	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
Patrolman		Police Dept		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
EDWARD J. BURNS		MARGARET HARTMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes World War #2		212-05-9672		Margaret Burns 600 N. Decker Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Large olefactory groove meningioma			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
35-29-65		The brain tumor		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5-27-65 to 6-18-65, that (I) (we) last saw the deceased alive on 6-18-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
LUMIO UEMATSU				6-18-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
LUMIO UEMATSU		Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		6/22/65		Baltimore National	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
Frederick Road					
25A. PREPARED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 21 1965		Robert E. Taylor, M.D.		Frederick D. Miller, Inc 3019 Monument Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6423	
BIRTH NO. 65 6423			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Kiser, Baby Boy			2. DATE AND HOUR OF DEATH 6/13/65 7 PM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI Hosp & Balto			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 6-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 8 N. Chester St		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	B. DATE OF BIRTH 6/13/65	9. AGE (In years last birthday) 12	If Under 1 Yr. Months: Days: Hours: Min. 12
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Ray			14. MOTHER'S MAIDEN NAME Joyce (Gallier)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	17. INFORMANT — ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 11			CAUSE OF DEATH (A) Hyaline Membrane Disease DUE TO (B) Prematurity & delivery DUE TO (C) via C-Section		INTERVAL BETWEEN ONSET AND DEATH 12 hrs
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/13/1965 to 6/13/1965 , that (I) (we) last saw the deceased alive on 6/13/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sidney Seidman M.D.			23B. DATE SIGNED 6/13/65		23C. PHYSICIAN'S NAME (Type) —
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 6-15-65		24C. NAME OF CEMETERY or CREMATORY Coh Funerary
24D. LOCATION (City, town, or county) (Street) Cath Ave Balto Md			25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		
25B. NAME OF REGISTRAR Robert E. Farley			25C. FUNERAL DIRECTOR Lee & Co		
25D. ADDRESS 1701 N. Patterson Rd					



65-2784/191

cee

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6424				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 6424	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				James F. FAULKNER		Sat June 19 1965		1:30 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY			
St. Agnes Hospital				Maryland		(65-2784/191-cee)			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore 21227		25-42	
				D. STREET ADDRESS (If rural, give location)		3213 Virginia Ave. (Lorena)			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)	
Male		White		Married		June 2 1889		76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ret R R Engineer				B & O R R		Trappe, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Frederick James Faulkner				Kate Bartlett					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				(RRB NoA-699-)(068-05-7173)		Mrs Alice Faulkner (Wife)		Same	
18. 331X I 358				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Recurrent CVA				hours?	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				DUE TO Original C-V-A 4 1/2 yrs prior with partial hemiparesis					
ANTECEDENT CAUSES				DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 3/19/51 to 6/19/65				19 to 6/19/65 19					
that (I) (we) last saw the deceased alive on 6/16/65 19				and that in (my) (our) opinion death occurred on the date					
and hour and from the causes stated above. (I) (We) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
C. Arthur Rossberg M.D.				6/21/65					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
C. ARTHUR ROSSBERG M.D.				2436 Washington Blvd 21230					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		June 22 65		Tues Meadowridge Cem., Dorsey, Howard Co., Md.		Curtis E. Evans			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUN 21 1965		Robert E. Faulkner		1400 S. Charles St Balto Md		21230			

CURTIS E. EVANS

C. H. HARRIS
J. H. HARRIS

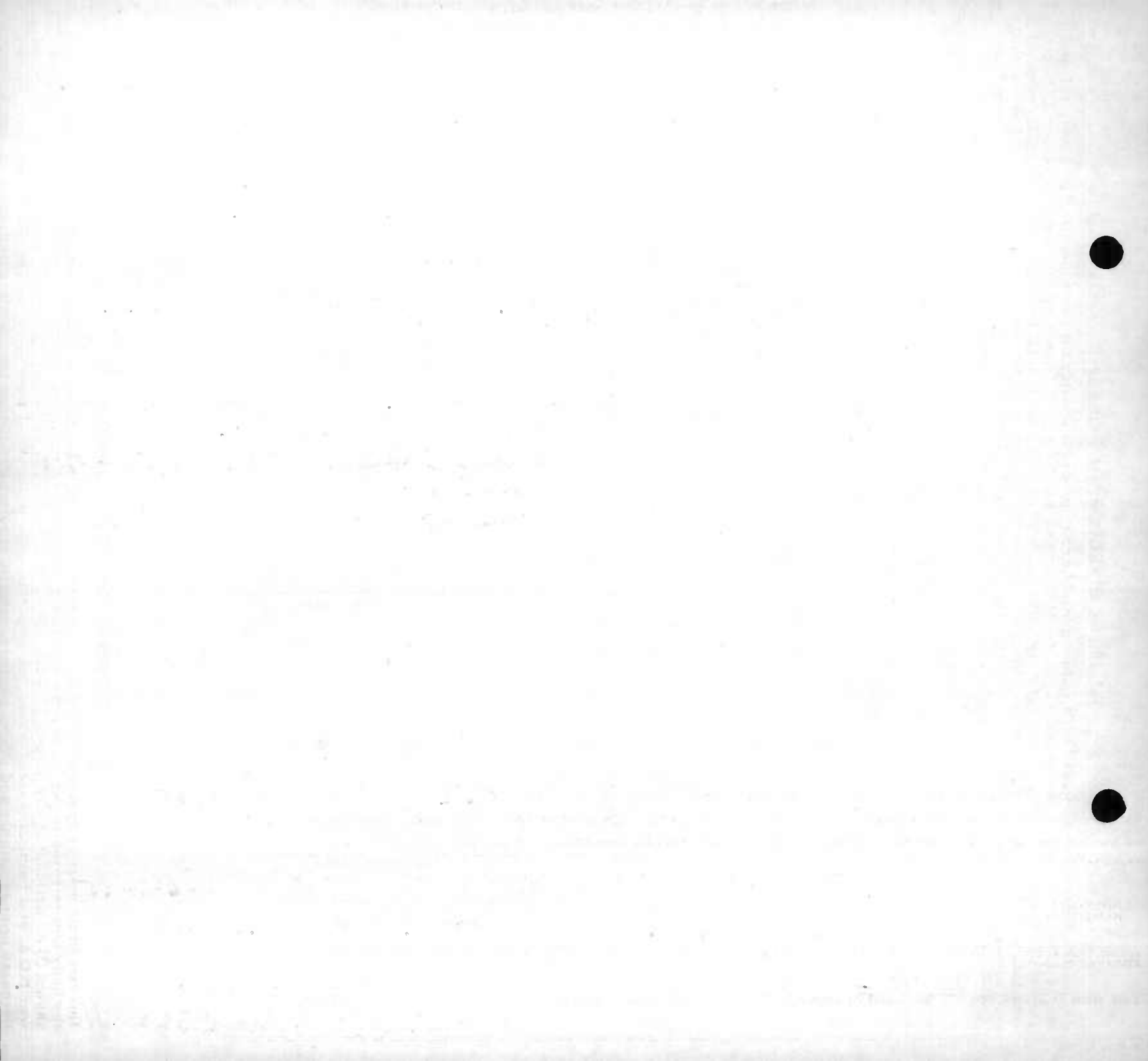
J. H. HARRIS

J. H. HARRIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

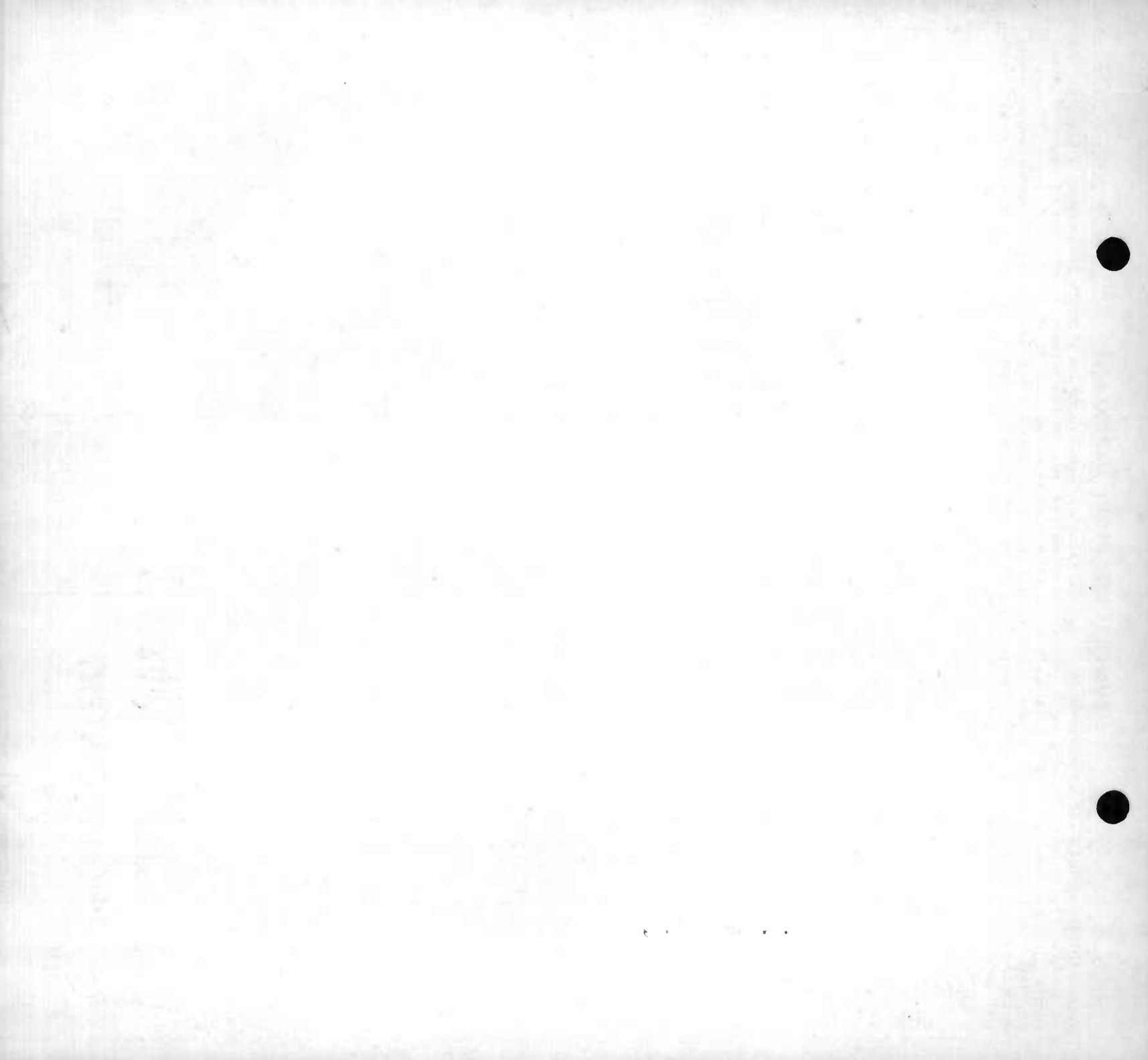
BIRTH NO. 65 6425				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6425	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Frank A. Passaro				2. DATE AND HOUR OF DEATH June 19, 1965 8:30 A.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 26-11 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 609 S. Clinton St.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Oct. 2, 1885	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer			10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) Nusco, Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Antonio Passaro			14. MOTHER'S MAIDEN NAME Anna Suriani		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 217-07-4468			17. INFORMANT Frank J. Passaro (Son)				ADDRESS 8135 Loch Ra-
18. 416X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Arteriosclerosis ven Blvd. INTERVAL BETWEEN ONSET AND DEATH 1952 - 1965				(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO Rheumatism			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1952 to 1965 June 19 , that (I) was lost saw the deceased alive on June 17 , 19 65 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) view the body after death.							
23A. SIGNATURE S. DeMarco, Jr.				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-21-65	
23C. PHYSICIAN'S NAME (Type) S. DeMarco, Jr.				23D. ADDRESS 715 N. Charles St., 21201			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/22/65		24C. NAME of CEMETERY or CREMATORY Lorraine Park Mausoleum		24D. LOCATION (City, town, or county) (State) 5608 Dogwood Rd. Woodlawn, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR Frank Della Noce		ADDRESS 322 S. High St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6426		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6426	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KUCHARSKI KOCHARSKI Leon		2. DATE AND HOUR OF DEATH 6/20/65 11 20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 2-02	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ Hosp		D. STREET ADDRESS (If rural, give location) 205 S. Regester St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 2/3/83	9. AGE (In years lost birthday) 82	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY BETH, STEEL		11. BIRTHPLACE (State or foreign country) Penn.	
13. FATHER'S NAME Frank Kocharche		14. MOTHER'S MAIDEN NAME Theresa			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS EDWARD KUCHARSKI 409 N. MALVERN AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Fecal Fistula and wound infection - (B) Small bowel obstruction (C)		INTERVAL BETWEEN ONSET AND DEATH 15 days 15 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia & Adenitis		10 days	
19A. DATE OF OPERATION 16/5/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Small bowel obstruction		20A. AUTOPSY? (Yes or No) 0	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/14 1965 to 6/20 1965, that (I) (we) last saw the deceased alive on 6/20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J.R. Stram M.D.		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/20/65	
23C. PHYSICIAN'S NAME (Type) J.R. Stram M.D.		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-23-65		24C. NAME OF CEMETERY or CREMATORY HOLY CROSS CEMETERY DUNDALK MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR JOHN M. WEBER & SONS INC. 401 S. CHESTER ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6427	
BIRTH NO. 65 6427		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WOJCICK, FRANK W.		2. DATE AND HOUR OF DEATH 6-18-65 7:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 103			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 2335 DUKER COURT			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 4-18-06	9. AGE (In years lost birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Wojcik			14. MOTHER'S MAIDEN NAME Hooper, Sofia		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-03-9921		17. INFORMANT OLGA WOJCICK 2335 DUKER CT.	
18. 527.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE - days		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) ACUTE MYOCARDIAL INFARCTION 7			
		(B) Emphysema			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-17 19 65 to 6-18 19 65 , that (I) (we) last saw the deceased alive on 6-18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ephraim B. Barzaga M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 6-18-65	
23C. PHYSICIAN'S NAME (Type) EPHRAIM B. BARZAGA		23D. ADDRESS CHURCH HOME & Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6-22-65	24C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CEM. DUNDALK		24D. LOCATION (City, town, or county) (State) MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR JOHN M. WEBER & SONS INC. ADDRESS 4015 CHESTER ST.	

FUNERAL DIRECTOR: IMPORTANT

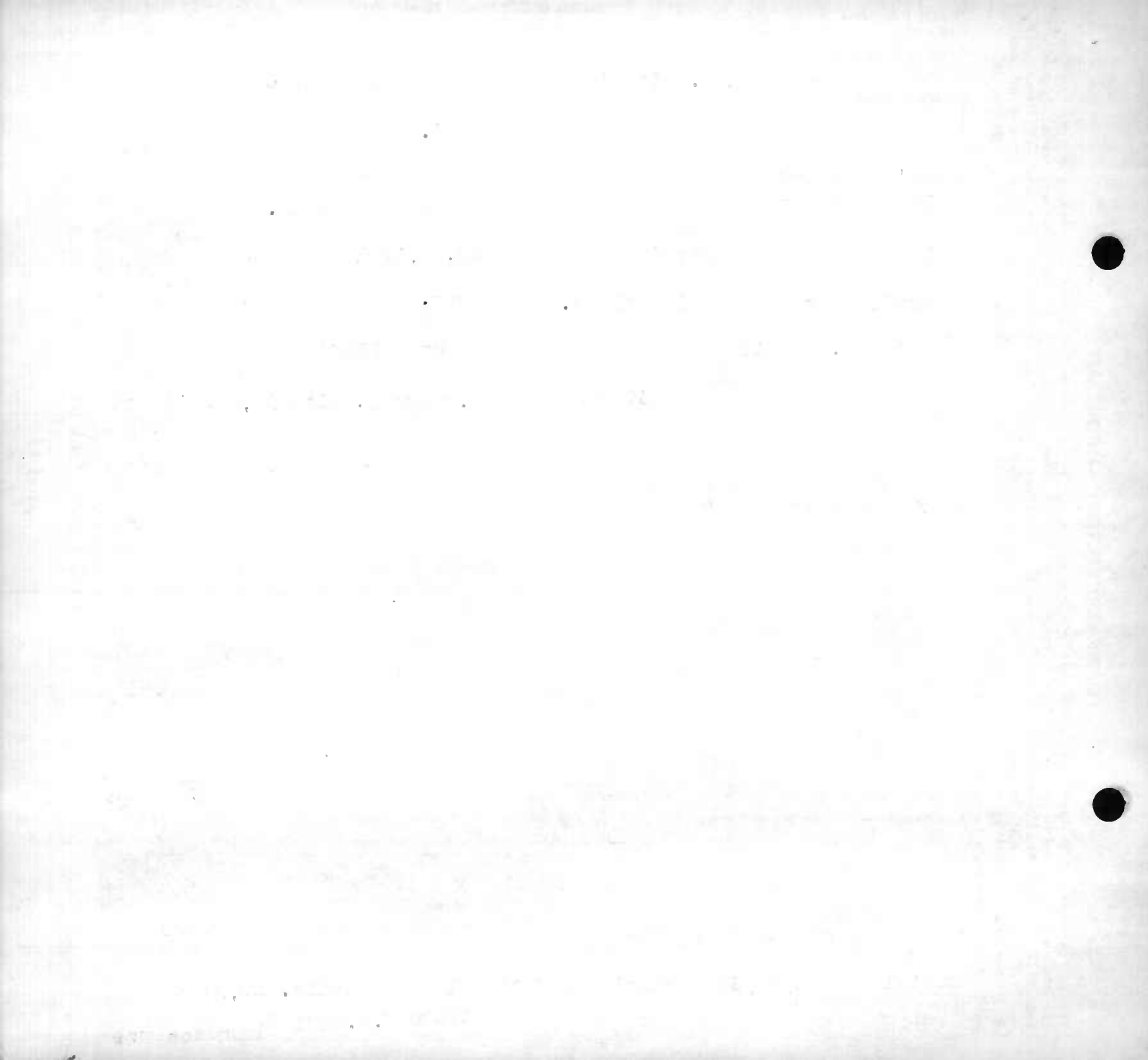
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6428				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6428	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Mary E. James		June 18, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Maryland General Hospital				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				144 N. Edgewood Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
Female	Colored	Widow	April 11, 1900	65			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Domestic				Florence, S. C.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Roberts				Sophia Williams			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		215-28-9147		Roscoe James - 119 N. Bentalou St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		Probable Cerebrovascular Accident - probably mins.	
ANTECEDENT CAUSES				(B) DUE TO		Hypertensive Cardiovascular disease at least 2 yrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 6/13/65 to 6/18/65, that (I) (we) last saw the deceased alive on 6/13/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
E. Saunders				6/18/65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Elijah Saunders				4713 W. Forest Park Ave., Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6-22-65		Arbutus Memorial Park		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 21 1965		Robert E. Fairbank		Charles R. Law		802 Madison Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 6429		CERTIFICATE OF DEATH		65 6429	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Samuel L. Ritchie			June 16/65		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Hood's Nursing Home 5313 Edmondson Ave			A. STATE Md. B. COUNTY 28-14 Baltimore D. STREET ADDRESS (If rural, give location) 403 Edsdale Rd.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Aug. 1, 1901	9. AGE (In years lost birthday) 63	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Man		10B. KIND OF BUSINESS OR INDUSTRY Olivetti Co.		11. BIRTHPLACE (State or foreign country) Penn.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Daniel B. Ritchie		14. MOTHER'S MAIDEN NAME Helen Gossard	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 067 093257		17. INFORMANT Mrs. Mary R. Ritchie, 403 Edsdale R	
18. 750101 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardiac failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Severe atherosclerosis		CAUSE OF DEATH (A) Cardiac failure DUE TO (B) Severe atherosclerosis DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) ✓	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1950 19 6/16/65 to 6/16/65 19 65 , that (I) (we) last saw the deceased alive on 6/17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. W. Scheye		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/19/65	
23C. PHYSICIAN'S NAME (Type) H. W. SCHEYE		23D. ADDRESS 3921 EDMONDSON AVE Balto, Md 29			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/18/65		24C. NAME of CEMETERY or CREMATORY Baltimore National	
24D. LOCATION Balto. 29, Md		25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965			
25B. NAME OF REGISTRAR R. E. F. F. F.		25C. FUNERAL DIRECTOR Witzke F.D. 4101 E Edmondson Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6430	
BIRTH NO. 65 6430		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John Bianco		2. DATE AND HOUR OF DEATH 6.16.65 10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Little Sisters of the Poor 1200 Valley St BALTIMORE md 21202		A. STATE md. B. COUNTY 10-01			
5. SEX m		6. RACE w		7. MARRIED NEVER MARRIED WIDOWED DIVORCED (specify)	
8. DATE OF BIRTH June 5, 1887		9. AGE (In years last birthday) 78		10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (State or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Bianco		14. MOTHER'S MAIDEN NAME Sarah Cammarata	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 218-09-2347		17. INFORMANT ADDRESS Little Srs. of The Poor 1200 Valley St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Acute coronary thrombosis (B) DUE TO Q.S.C. U.D. (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 1963 to 6.16.1965, that (I) (we) last saw the deceased alive on 6.16.1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Stanley Ankudas M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23B. DATE SIGNED 6.17.65		23C. PHYSICIAN'S NAME (Type) DR. STANLEY ANKUDAS M.D.		23D. ADDRESS 1802 W. Baltimore St.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 6/18/65		24C. NAME OF CEMETERY or CREMATORY Cathedral	
24D. LOCATION (City, town, or county) (State) Baltimore		25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.	
25C. FUNERAL DIRECTOR Philip Henry Soro Orleans St		25D. ADDRESS 2024			

Charles W. Smith
June 2, 1892

Thomas (Gentry)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

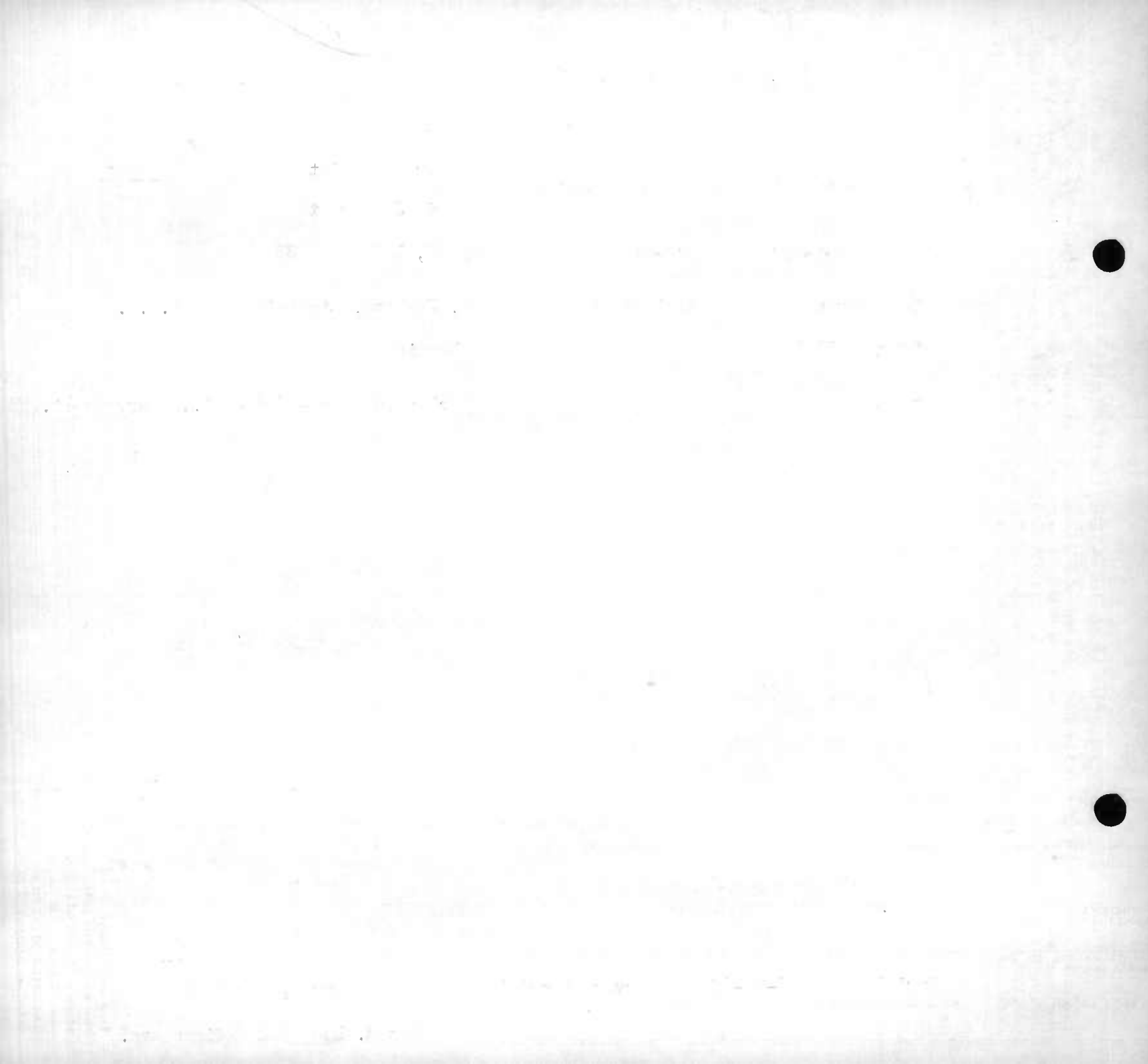
Baltimore City Health Department				Registered No. 65 6431	
BIRTH NO. 65 6431		CERTIFICATE OF DEATH		Registered No. 65 6431	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) NEILS P. HANSEN			2. DATE AND HOUR OF DEATH JUNE 18 1965 6:00 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-02		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 UNION MEMORIAL HOSPITAL			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21214		
D. STREET ADDRESS (If rural, give location) 4701 ELSRODE AVE					
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-8-97	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) DENMARK		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME MONGER HANSEN			14. MOTHER'S MAIDEN NAME ANNA JENSEN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -	17. INFORMANT Chart		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Cirrhosis of Liver DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10 years
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION APRIL 27 1965 MARCH 16 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Portal hypertension		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work Not White At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 2-21 1965 to 6-18 1965, that (H) (we) last saw the deceased alive on June 18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ellen Ann Dagon Millan M.D. Attending Phys. Med. Director Staff Phys. X				23B. DATE SIGNED June 18, 1965	
23C. PHYSICIAN'S NAME (Type) ELLEN ANN DAGON MILLAN		23D. ADDRESS Union Memorial Hosp. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/18/65		24C. NAME of CEMETERY or CREMATORY GARDENS FAITH BALTO CO.	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR P.A. HEEMANN 6067 HARFORD RD.	

LLA V. LAC. LLA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

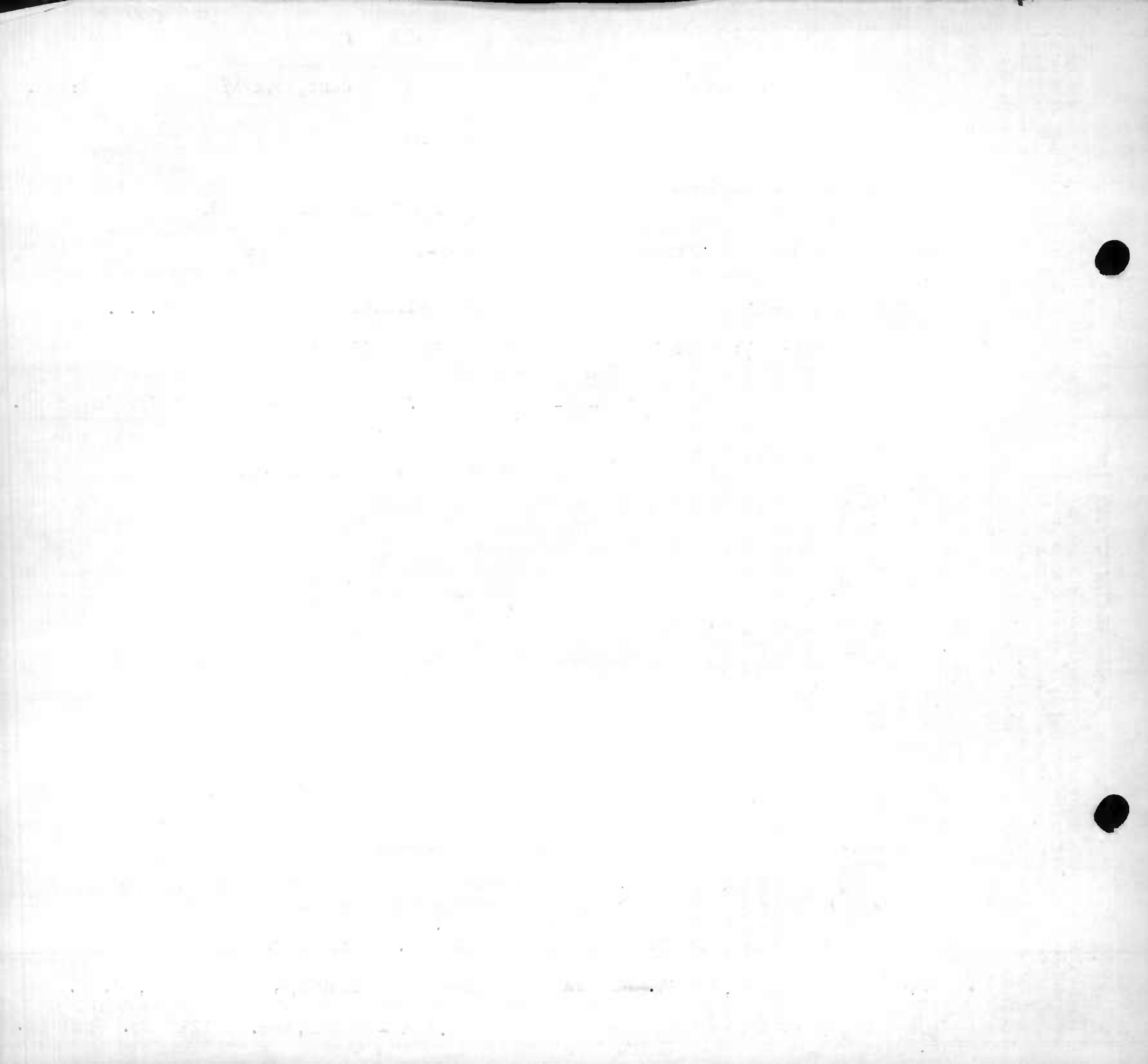
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 6432									
CERTIFICATE OF DEATH									
Registered No. 65 6432									
1. NAME OF DECEASED (Type or Print) BULLETT, CHARLES E.					2. DATE AND HOUR OF DEATH June 17, 1965 10:03 P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital					4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Balt. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Sparrows Point D. STREET ADDRESS (If rural, give location) 805 "J" Street				
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH May 25, 1877	9. AGE (In years last birthday) 88	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel worker			10B. KIND OF BUSINESS OR INDUSTRY Steel Plant		11. BIRTHPLACE (State or foreign country) Mt. Jackson, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry Bullett			14. MOTHER'S MAIDEN NAME Fannie						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Charles Bullett - 805 J St., Sparrows Pt., Md				
18. 330.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					CAUSE OF DEATH (A) Pulmonary embolism DUE TO (B) _____ DUE TO (C) _____			INTERVAL BETWEEN ONSET AND DEATH 9 hrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pancreatic appendicitis with peritonitis					7 days				
19A. DATE OF OPERATION 6/10/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PANCREA-APPENDICITIS		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 6/10 19 65 to 6/17 19 65 , that (I) (we) last saw the deceased alive on 6/17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Sherwood Ewell Wilson M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 6/17/65	
23C. PHYSICIAN'S NAME (Type) Sherwood Ewell Wilson M.D.					23D. ADDRESS S. Balto. Hosp. 1213 Light St. Balto. Md				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-20-65		24C. NAME OF CEMETERY or CREMATORY Carver Memorial Park			24D. LOCATION (City, town, or county) (State) Laurel, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965			25B. NAME OF REGISTRAR Robert E. Farley			25C. FUNERAL DIRECTOR Charles R. Law			
ADDRESS 802 Madison Ave.									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

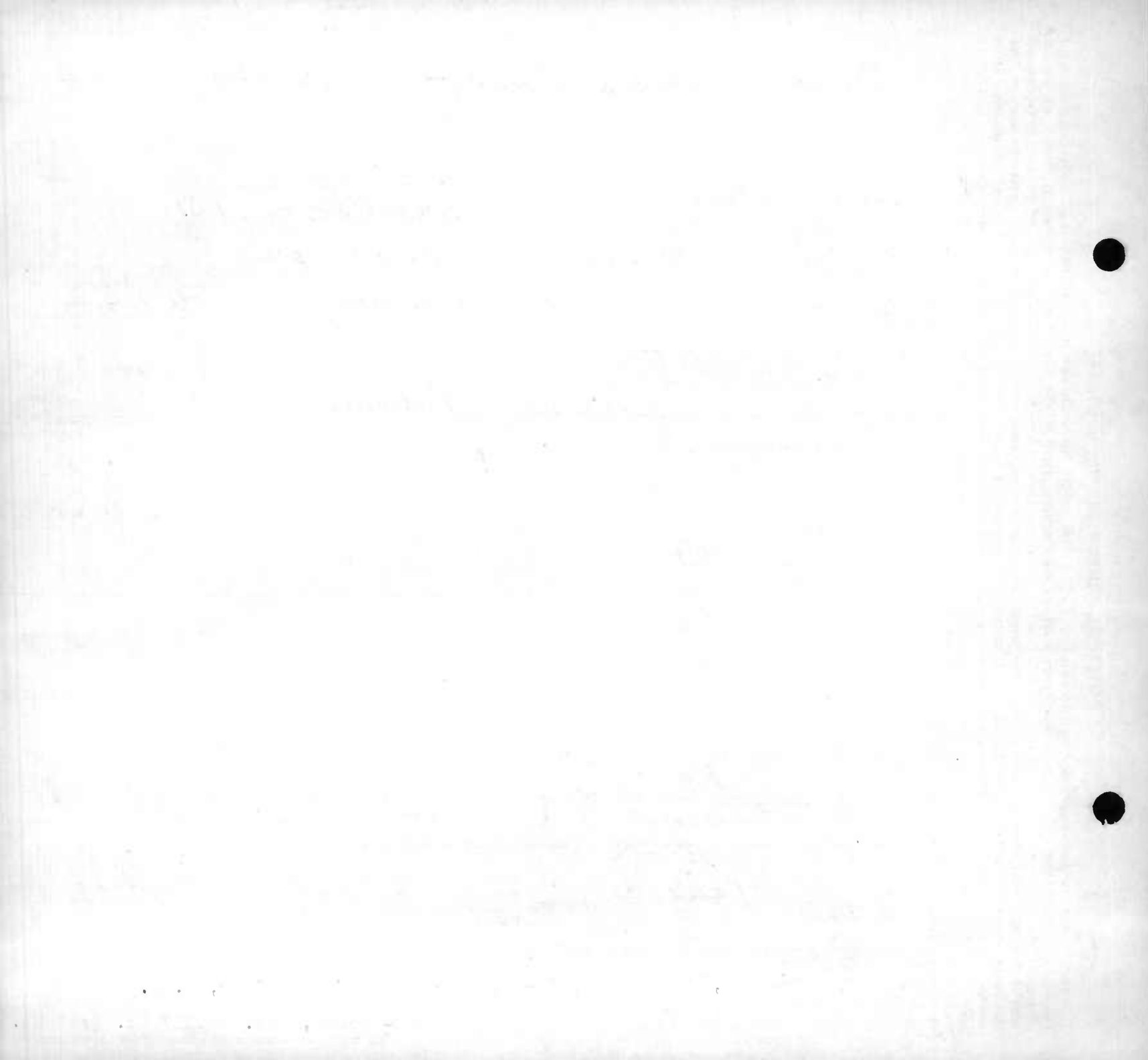
BIRTH NO. 65 6433		BALTIMORE CITY HEALTH DEPARTMENT REGISTERED NO. 65 6433	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) LORD, HARRY		2. DATE AND HOUR OF DEATH June, 18, 1965 8:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE New York B. COUNTY Bayside C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 201-23 Harse Harding Blvd.	
5. SEX Male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 1-6-10
9. AGE (In years last birthday) 55		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Union Representative		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Lithenstein		14. MOTHER'S MAIDEN NAME Lena Miller	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 115-01-1633	
17. INFORMANT Irene T. Lord		ADDRESS 201-23 Harse Harding Blvd.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction DUE TO (A) Acute myocardial infarction (B) DUE TO (C) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 18 19 65 to June 18 19 65 , that (I) (we) last saw the deceased alive on June 18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Fausto Q. Aquino, Jr. M.D.		23B. DATE SIGNED June 18, 1965	
23C. PHYSICIAN'S NAME (Type) Fausto Q. AQUINO jr		23D. ADDRESS 1400 N. Caroline Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal	24B. DATE June 19, 65	24C. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery	24D. LOCATION (City, town, or county) (State) Flushing Long Island, N. Y.
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965	25B. NAME OF REGISTRAR Robert E. Farkner	25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6434		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6434	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <i>David Parker Gravatt</i>		2. DATE AND HOUR OF DEATH <i>6-19-65 1AM. 1 A M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Penna.</i> B. COUNTY <i>K-35</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>The Hospital For The Women of Md.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Pottstown</i>			
		D. STREET ADDRESS (If rural, give location) <i>548 Chestnut St.</i>			
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>3-17-1883</i>	9. AGE (In years last birthday) <i>82</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unknown</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>George Gravatt</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unknown</i>		16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT <i>Patients' chart</i>	
18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>C.H.F 2° HASCD.</i> DUE TO (B) <i>Gastric ulcer.</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>20 years</i> <i>1 year</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no.</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <i>6-14</i> 19 <i>65</i> to <i>6-19</i> 19 <i>65</i> , that (I) <u>(we)</u> lost saw the deceased alive on <i>6-19</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J.K. Chow</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6-19-65.</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>June 19, 65</i>		24C. NAME of CEMETERY or CREMATORY <i>River Side Cemetery</i>	
		24D. LOCATION (City, town, or county) <i>Toms River, N. J.</i>		(State)	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 21 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fadden</i>		25C. FUNERAL DIRECTOR <i>Wm Cook-Brooks, Inc.</i>	
				ADDRESS <i>1217 St. Paul St.</i>	



By approval of medical examiner
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6435	
BIRTH NO. 65 6435		M.E. CASE NO.		CERTIFICATE OF DEATH	
NAME OF DECEASED (Type or Print) Stark Delmer E. Blake		DATE AND HOUR OF DEATH 6-18-65 2:13 P.M.			
PLACE OF DEATH IN BALTIMORE, MARYLAND (If not in hospital or institution, give street address or location) CERTIFICATE CORRECTED 7-7-65 Johns Hopkins Hospital		USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) WEST VIRGINIA			
FULL NAME OF HOSPITAL OR INSTITUTION		CITY OR TOWN (If outside city limits, write RURAL and give township) S. CHARLESTON			
		STREET ADDRESS (If rural, give location) 312 SHEPHERD AVENUE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-19-20	9. AGE (In years lost birthday) 45	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemical Worker		10B. KIND OF BUSINESS OR INDUSTRY Union Carbide & Carbon		11. BIRTHPLACE (State or foreign country) Sandyville, W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES EBERT BLAKE		14. MOTHER'S MAIDEN NAME SARAN FRANCES DUKE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 285-14-7382		17. INFORMANT Mrs. Freda Blake	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Generalized peritonitis		INTERVAL BETWEEN ONSET AND DEATH 10 days	
ANTECEDENT CAUSES		perforated pyloric ulcer		11 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Corticosteroid therapy		12 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Severe diabetes mellitus & Ketoacidosis		25 yrs & 10 days	
19A. DATE OF OPERATION 6-18		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED perforated ulcer		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-26 19 65 to 6-18 19 65, that (we) lost saw the deceased alive on 6-18 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Darryl Fisher, M.D.				23B. DATE SIGNED 6-18-65	
23C. PHYSICIAN'S NAME (Type) DR. DARRYL FISHER				23D. ADDRESS JOHN HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-19-65		24C. NAME OF CEMETERY OR CREMATORY RIPLEY CEMETERY	
24D. LOCATION WEST VIRGINIA		24E. DATE REC'D BY HEALTH DEPT. JUN 21 1965		24F. NAME OF REGISTRAR Robert E. Fisher, M.D.	
24G. FUNERAL DIRECTOR		24H. ADDRESS		24I. NAME OF CEMETERY OR CREMATORY	
24J. DATE REC'D BY HEALTH DEPT.		24K. NAME OF REGISTRAR		24L. FUNERAL DIRECTOR	
24M. ADDRESS		24N. NAME OF CEMETERY OR CREMATORY		24O. DATE REC'D BY HEALTH DEPT.	
24P. NAME OF REGISTRAR		24Q. FUNERAL DIRECTOR		24R. ADDRESS	
24S. DATE REC'D BY HEALTH DEPT.		24T. NAME OF REGISTRAR		24U. FUNERAL DIRECTOR	
24V. ADDRESS		24W. NAME OF CEMETERY OR CREMATORY		24X. DATE REC'D BY HEALTH DEPT.	
24Y. NAME OF REGISTRAR		24Z. FUNERAL DIRECTOR		24AA. ADDRESS	
24AB. DATE REC'D BY HEALTH DEPT.		24AC. NAME OF REGISTRAR		24AD. FUNERAL DIRECTOR	
24AE. ADDRESS		24AF. NAME OF CEMETERY OR CREMATORY		24AG. DATE REC'D BY HEALTH DEPT.	
24AH. NAME OF REGISTRAR		24AI. FUNERAL DIRECTOR		24AJ. ADDRESS	
24AK. DATE REC'D BY HEALTH DEPT.		24AL. NAME OF REGISTRAR		24AM. FUNERAL DIRECTOR	
24AN. ADDRESS		24AO. NAME OF CEMETERY OR CREMATORY		24AP. DATE REC'D BY HEALTH DEPT.	
24AQ. NAME OF REGISTRAR		24AR. FUNERAL DIRECTOR		24AS. ADDRESS	
24AT. DATE REC'D BY HEALTH DEPT.		24AU. NAME OF REGISTRAR		24AV. FUNERAL DIRECTOR	
24AW. ADDRESS		24AX. NAME OF CEMETERY OR CREMATORY		24AY. DATE REC'D BY HEALTH DEPT.	
24AZ. NAME OF REGISTRAR		24BA. FUNERAL DIRECTOR		24BB. ADDRESS	
24BC. DATE REC'D BY HEALTH DEPT.		24BD. NAME OF REGISTRAR		24BE. FUNERAL DIRECTOR	
24BF. ADDRESS		24BG. NAME OF CEMETERY OR CREMATORY		24BH. DATE REC'D BY HEALTH DEPT.	
24BI. NAME OF REGISTRAR		24BJ. FUNERAL DIRECTOR		24BK. ADDRESS	
24BL. DATE REC'D BY HEALTH DEPT.		24BM. NAME OF REGISTRAR		24BN. FUNERAL DIRECTOR	
24BO. ADDRESS		24BP. NAME OF CEMETERY OR CREMATORY		24BQ. DATE REC'D BY HEALTH DEPT.	
24BR. NAME OF REGISTRAR		24BS. FUNERAL DIRECTOR		24BT. ADDRESS	
24BU. DATE REC'D BY HEALTH DEPT.		24BV. NAME OF REGISTRAR		24BW. FUNERAL DIRECTOR	
24BX. ADDRESS		24BY. NAME OF CEMETERY OR CREMATORY		24BZ. DATE REC'D BY HEALTH DEPT.	
24CA. NAME OF REGISTRAR		24CB. FUNERAL DIRECTOR		24CC. ADDRESS	
24CD. DATE REC'D BY HEALTH DEPT.		24CE. NAME OF REGISTRAR		24CF. FUNERAL DIRECTOR	
24CG. ADDRESS		24CH. NAME OF CEMETERY OR CREMATORY		24CI. DATE REC'D BY HEALTH DEPT.	
24CJ. NAME OF REGISTRAR		24CK. FUNERAL DIRECTOR		24CL. ADDRESS	
24CM. DATE REC'D BY HEALTH DEPT.		24CN. NAME OF REGISTRAR		24CO. FUNERAL DIRECTOR	
24CP. ADDRESS		24CQ. NAME OF CEMETERY OR CREMATORY		24CR. DATE REC'D BY HEALTH DEPT.	
24CS. NAME OF REGISTRAR		24CT. FUNERAL DIRECTOR		24CU. ADDRESS	
24CV. DATE REC'D BY HEALTH DEPT.		24CW. NAME OF REGISTRAR		24CX. FUNERAL DIRECTOR	
24CY. ADDRESS		24CZ. NAME OF CEMETERY OR CREMATORY		24DA. DATE REC'D BY HEALTH DEPT.	
24DB. NAME OF REGISTRAR		24DC. FUNERAL DIRECTOR		24DD. ADDRESS	
24DE. DATE REC'D BY HEALTH DEPT.		24DE. NAME OF REGISTRAR		24DE. FUNERAL DIRECTOR	
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24DE. DATE REC'D BY HEALTH DEPT.		24DE.			

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65 6436

BALTIMORE CITY HEALTH DEPARTMENT

65 6436

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH N. KOLB

2. DATE AND HOUR PRONOUNCED DEAD

6/18/65 10:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

521 S. 46th St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

4/16/68

9. AGE (In years last birthday)

17

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

School

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph N. Kolb Sr.

14. MOTHER'S MAIDEN NAME

Viola B. Hilditch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Joseph N. Kolb Sr., 521 S 46th St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple injuries DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

German Hill Rd. and Delbert Ave.

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) (Min.)

6 18 65 9:45 p.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

passenger in auto

which struck pole

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

6/19/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

6/22/65

23C. NAME of CEMETERY or CREMATORY

Western Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUN 21 1965

24B. NAME OF REGISTRAR

Robert E. Jones

24C. FUNERAL DIRECTOR

ADDRESS

Wm Cook-Brooks, Inc, 1217 St Paul St
Baltimore 2, Md

WALTER PORCE

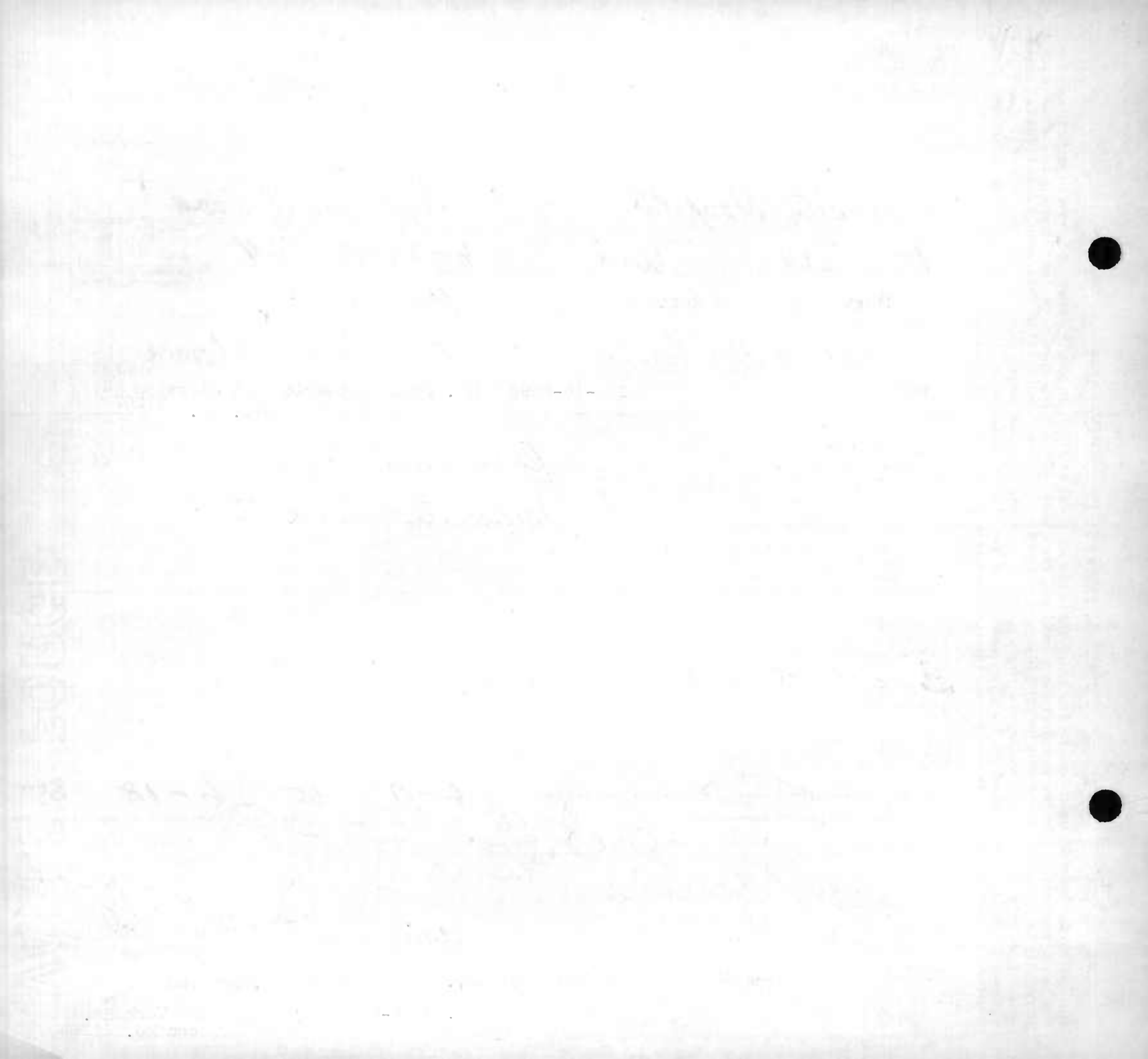
WAS DEPT

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
Registered No. 65 6437									
BIRTH NO. 65 6437		M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <i>Clementine Marie Del Gaudio</i>					2. DATE AND HOUR OF DEATH <i>6-18-65 6:15 P. M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> COUNTY <i>Baltimore</i>				
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i> (If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Phoenix</i>				
					D. STREET ADDRESS (If rural, give location) <i>Paper Mill Road</i>				
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Wid</i>		8. DATE OF BIRTH <i>6-29-00</i>	9. AGE (In years last birthday) <i>64</i>	10. Under 1 Yr. Months: Days		11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Sigmund Michaels</i>					14. MOTHER'S MAIDEN NAME <i>Leopoldine Klomm</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>213-10-8690</i>		17. INFORMANT ADDRESS <i>Mr. Frank DelGaudio 1612 Kirkwood Rd Balt. Md. 21207</i>				
18. <i>410X I</i> CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Renal shut down</i>					INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <i>Mitral stenosis; RHD</i>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>6-16-65</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Mitral commissurotomy</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>6-7-1965</i> to <i>6-18-1965</i> that (I) (we) last saw the deceased alive on <i>6-18-1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Masses Maeshiro</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6-18-65</i>		
23C. PHYSICIAN'S NAME (Type) <i>Masses Maeshiro</i>					23D. ADDRESS <i>University Hospital</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>June 22 1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 21 1965</i>			25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook-Brooks Towson 1050 York Rd. Towson Md. 21204</i>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6438	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) MARY KADAN CADEN			2. DATE AND HOUR OF DEATH 6-16-65 2:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) House in the Pines 2525 W. Belvedere			A. STATE Md B. COUNTY BALTIMORE		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) 5370			D. STREET ADDRESS (If rural, give location) 533. WYNGATE RD. TIMONIUM		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH SEPT. 29, 1880	9. AGE (In years last birthday) 84	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			11. BIRTHPLACE (State or foreign country) BALTIMORE		
13. FATHER'S NAME SHOFT			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 216-01-2269		
17. INFORMANT MRS THOMAS L. YOUNG JR.			ADDRESS 533 WYNGATE RD.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Pneumonia infection			INTERVAL BETWEEN ONSET AND DEATH 2-3 2-3		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 13 1965 to June 14 1965, that (I) (we) last saw the deceased alive on June 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lester M. Kolman M.D.			23B. DATE SIGNED 6/17/65		
23C. PHYSICIAN'S NAME (Type) Lester M. Kolman M.D.			23D. ADDRESS 3700 Park Hghts. Ave.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-19-65		24C. NAME of CEMETERY or CREMATORY BOHEMIAN NATIONAL	
24D. LOCATION BALTIMORE Md		25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wm. Coyle - Brooks-Townson, 1450 York Rd.			

1945-46 345, 114, 52

1946-47 345, 114, 52

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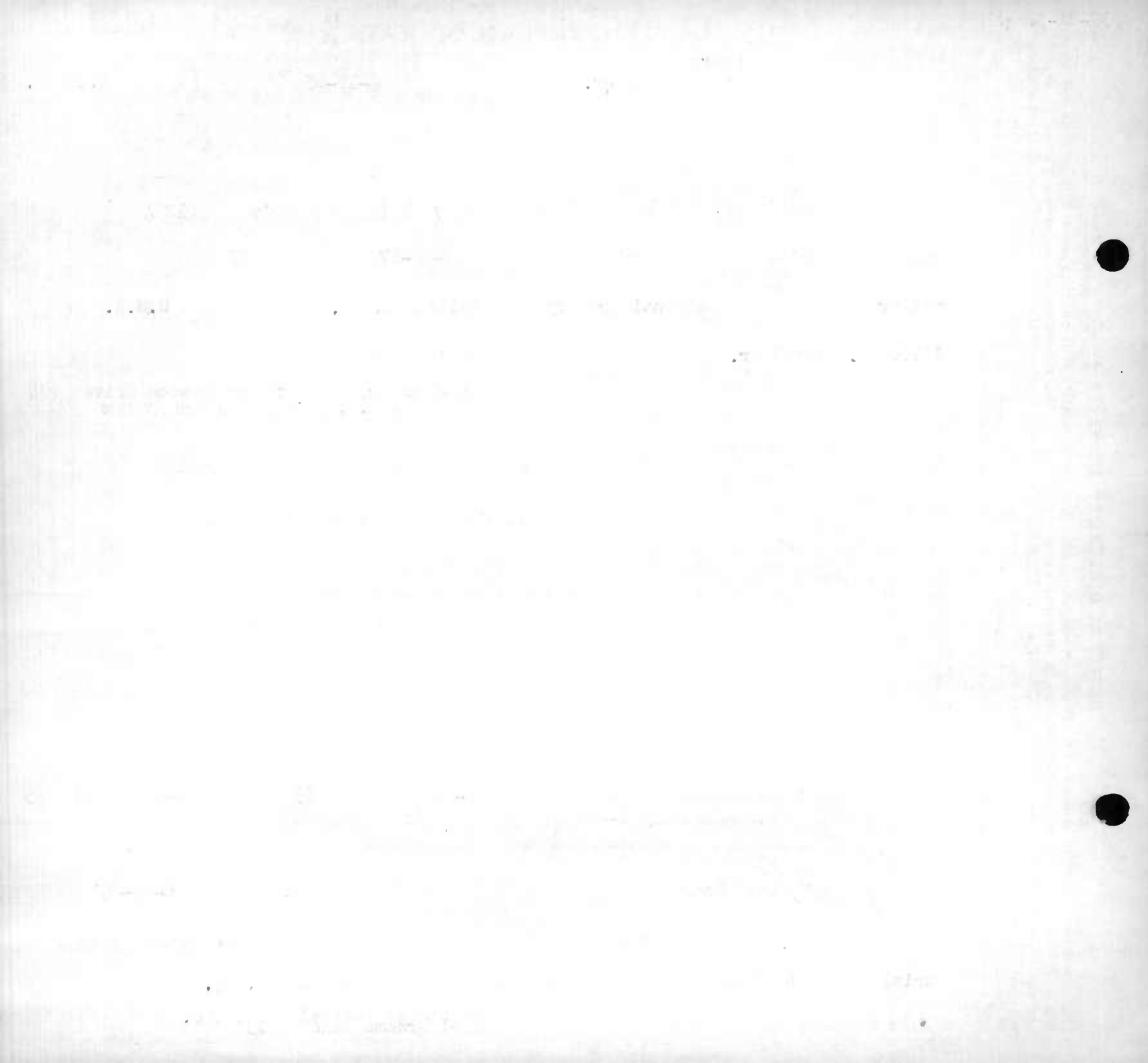
345, 114, 52

1947-48 345, 114, 52

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

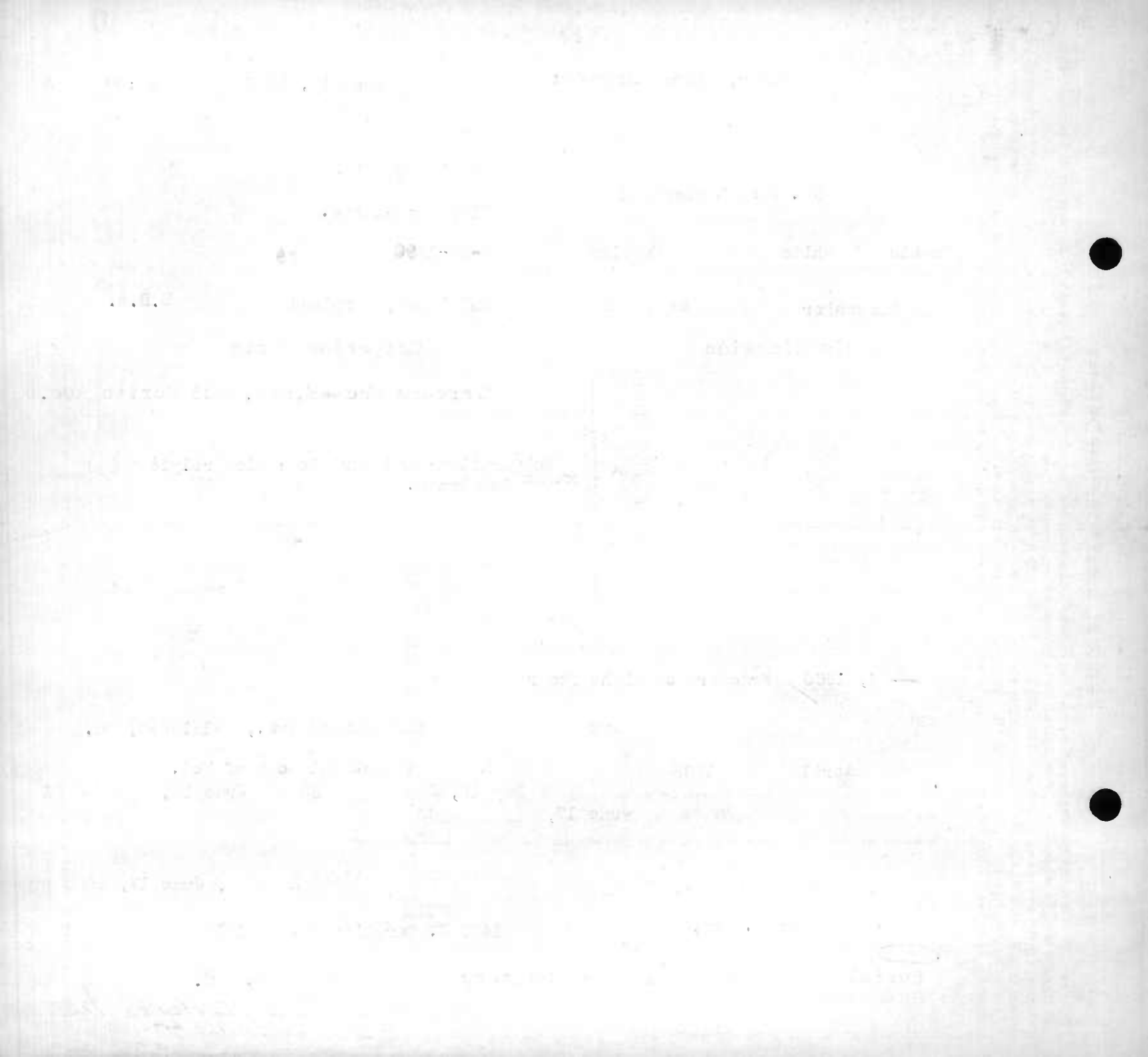
BIRTH NO. 65 6439		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6439	
M.E. CASE NO.		1. NAME OF DECEASED Henry William Bensel Jr.		2. DATE AND HOUR OF DEATH 6-18-65 1:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 7267 Bridgewood Drive #21224			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-24-17	9. AGE (In years last birthday) 47	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Battler		10B. KIND OF BUSINESS OR INDUSTRY National Brewery		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William H. Bensel Sr.		14. MOTHER'S MAIDEN NAME Ellen Alt	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Florence Bensel 7267 Bridgewood Drive #24 RECORDS: B.C.H. 4940 Eastern Avenue #21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Possible Acute Myocardial Infarction DUE TO (B) Arterio Sclerotic Heart Disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-18 19 65 to 6-18 19 65, that (I) (we) lost saw the deceased alive on 6-18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Howard Rathbun		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-18-65	
23C. PHYSICIAN'S NAME (Type) Dr. Howard Rathbun		23D. ADDRESS 4940 Eastern Avenue #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/21/65		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D. BY HEALTH DEPT. JUN 21 1965			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Abrams Lane #13			
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

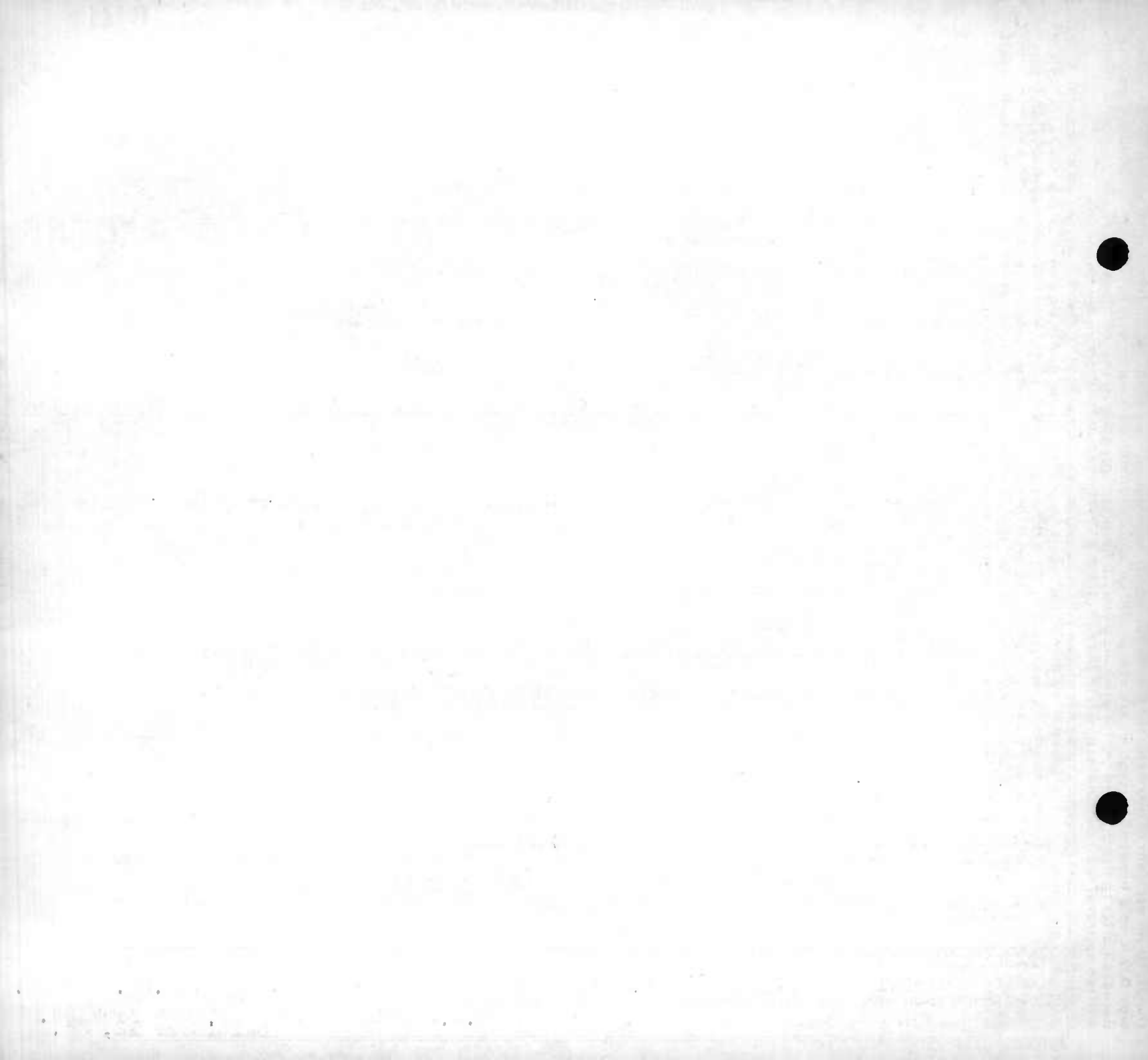
BIRTH NO. 65 6440		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6440	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Becker, Clara Margaret		June 17, 1965		10:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 8-01	
St. Joseph Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore 21213	
		D. STREET ADDRESS (If rural, give location)		3109 Mareco Ave.	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-30-1890	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker		at home		Baltimore, Maryland	
13. FATHER'S NAME Louis Richwien		14. MOTHER'S MAIDEN NAME Catherine Kratz		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Clarence Becker, son, 5925 Eurith Ave. 6	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 286.5 IY-E902.0		CAUSE OF DEATH (A) Dehydration; malnutrition; electrolyte imbalance. (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		MEDICAL EXAMINER'S SIGNATURE J. G. Gan			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Fracture @ femur			
19A. DATE OF OPERATION May 6, 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture of right femur		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3109 Mareco Ave., Baltimore, Md.	
21D. TIME OF INJURY (APPROX.) April 1965		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Patient fell out of bed.	
22. I certify that (I) (this hospital) attended the deceased from May 15, 1965 to June 17, 1965, that (I) (we) last saw the deceased alive on June 17, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Juan G. Gan		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 17, 1965	
23C. PHYSICIAN'S NAME (Type) Juan G. Gan,		23D. ADDRESS M.D. 1400 N. Caroline St., Baltimore, Maryland			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/21/65		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Finken		25C. FUNERAL DIRECTOR ADDRESS SCHUMAKER FUNERAL HOMES INC. 3331 BREHMS LA.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6441	
BIRTH NO. 65 6441		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HALL, SILAS BALDWIN		2. DATE AND HOUR OF DEATH 6/20/65 1 8.30 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 12-02			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL 827 LINDEN AVE BALTO 1, MD		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 3106 ABELL AVE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 7/19/92	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-		10B. KIND OF BUSINESS OR INDUSTRY ST. OF MD. - UNEMPLOYMENT OFFICE		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME MONTICELLO HALL		12. CITIZEN OF WHAT COUNTRY? U.S.A			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 217-15-6172		17. INFORMANT MARYLAND GENERAL HOSP 827 LINDEN AVE	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) COMPLETE HEART BLOCK Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/19 19 65 to 6/20 19 65 , that (I) (we) last saw the deceased alive on 6/20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Pietro Lestman				23B. DATE SIGNED 6/20/65	
23C. PHYSICIAN'S NAME (Type) LASTRUCCI PIETRO		23D. ADDRESS MARYLAND GEN HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/23/1965	24C. NAME OF CEMETERY or CREMATORY Lorraine Park		24D. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co. Md.	
25A. DATE REC'D. BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co., 14905 York Rd. Baltimore 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 6442	
BIRTH NO. 65 6442		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Dr. GEORGE J. WOHRNA		2. DATE AND HOUR OF DEATH 19 Jun 65 1030 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3821 CRESTLYN RD.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 701			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 3821 CRESTLYN, RD.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-9-1887	9. AGE (In years last birthday) 78	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOCTOR		10B. KIND OF BUSINESS OR INDUSTRY DENTIST		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALBERT WOHRNA			14. MOTHER'S MAIDEN NAME ELOISE N. VON NEUBERG				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-05-8955		17. INFORMANT ADDRESS MRS. DOROTHY M. WOHRNA (SAME)			
18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Bronchopneumonia (B) DUE TO Hypertensive Cardiovascular Dis			INTERVAL BETWEEN ONSET AND DEATH 1 wk sen. yrs		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 60 to 19 Jun 19 65 , that (I) (we) last saw the deceased alive on 19 Jun 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Hulla				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 20 Jun 65	
23C. PHYSICIAN'S NAME (Type) J. Hulla				23D. ADDRESS 2214 E Fayette St 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/23/1965		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Parkville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.			

WONDER

MARYLAND

BALTIMORE

311 CRESTLYN RD.

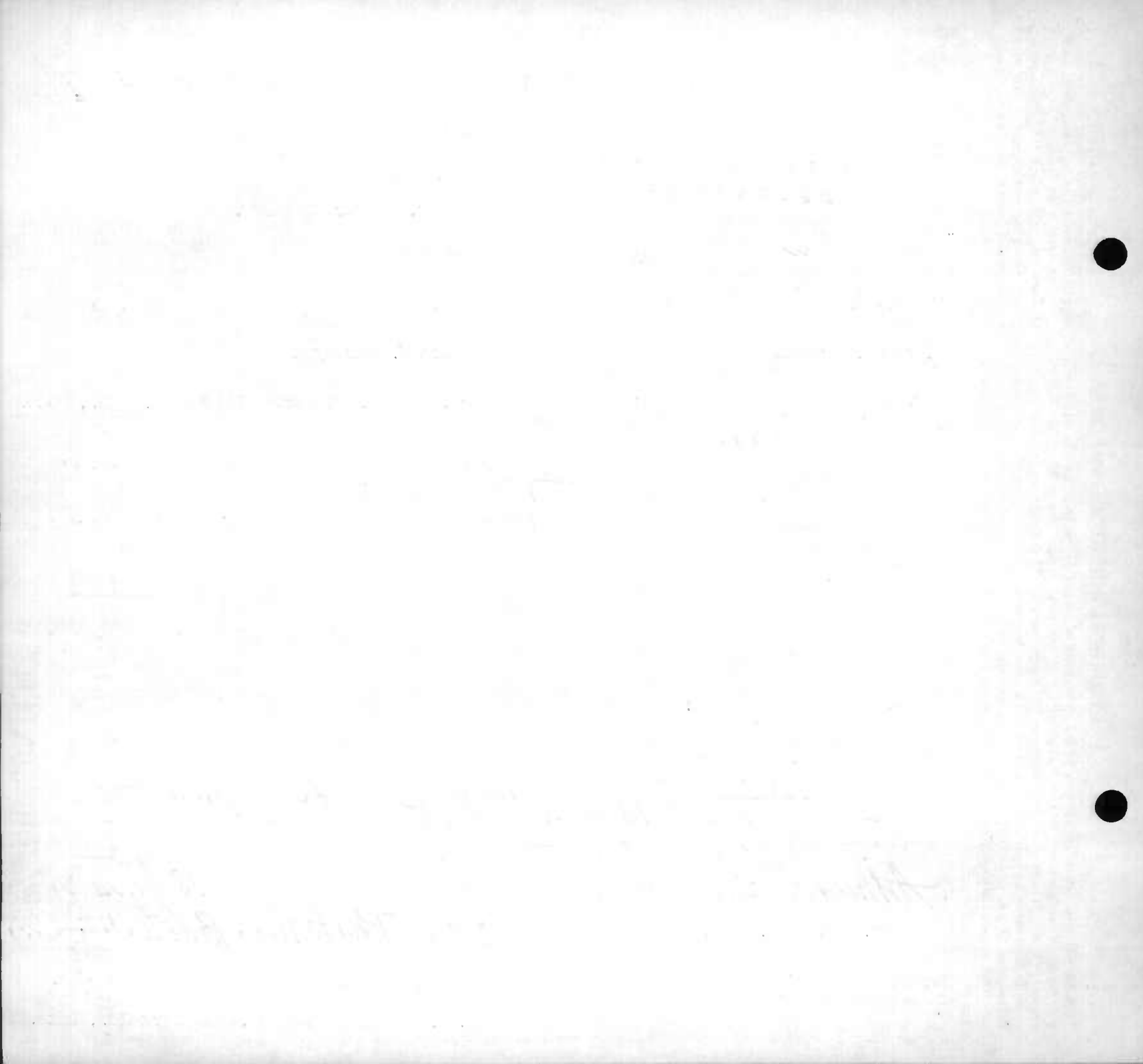
311 CRESTLYN RD.

MARY WHITE MARRIAGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6443	
BIRTH NO. 65 6443		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BESSIE R. PORTER		2. DATE AND HOUR OF DEATH JUNE 18, 1965 9 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-89		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION HOUSE IN THE PINES BELEVEDERE		D. STREET ADDRESS (If rural, give location) 505 W. University Pkwy.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 12-9-1886	9. AGE (In years lost birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Isaac J. Browne		14. MOTHER'S MAIDEN NAME Sara V. Burgoyne	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Sara V. Finnerty 3545 Newland Rd., Balto.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 442 X+1 171X		CAUSE OF DEATH (A) Cardio renal vascular disease with C.V.A. 2 days ago. (B) Carcinoma of cervix (C)		INTERVAL BETWEEN ONSET AND DEATH 4 yrs. 18 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 1946 to present 19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (WE) (did) (did not) view the body after death.					
23A. SIGNATURE Arthur G. Swinski M.D.				23B. DATE SIGNED 18 June 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Arthur G. Swinski		23D. ADDRESS 836 Park Ave. Balto. Md 21201			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-21-65		24C. NAME OF CEMETERY or CREMATORY Rose Hill	
24D. LOCATION Hagerstown		24E. (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4905 York Rd., Balto. 12	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6444	
BIRTH NO. 65 6444		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Carrie Eleanor Dienstbach</i>		2. DATE AND HOUR OF DEATH <i>June 16, 1965 1 3 P M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hosp.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Towson 63-00</i> D. STREET ADDRESS (If rural, give location) <i>114 Linden Terrace</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>2/13/86</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HSWF</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>WILLIAM W. JOHNSON</i>		14. MOTHER'S MAIDEN NAME <i>HATTIE M. HAMMOND</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>UMH CHART</i>	
18. <i>163X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Carcinoma of lung</i> DUE TO (B) <i>—</i> DUE TO (C) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 MONTHS</i>	
19A. DATE OF OPERATION <i>0 NONE</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>—</i>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>—</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>—</i>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <i>—</i>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>—</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>6/12/1965</i> to <i>6/16/1965</i> , that (I) (we) last saw the deceased alive on <i>6/16/1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A. Laird Bryson</i>		M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/16/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>A. LAIRD BRYSON</i>		23D. ADDRESS <i>UNION MEMORIAL HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>JUN. 21, 1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Parkville, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 21 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Tadmor</i>		25C. FUNERAL DIRECTOR <i>John Brunst & Sons 610-612 York</i>	

40-51-70 AM

65 6445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 6445

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Bertha Knapp (Bertha E. Knapp)

2. DATE AND HOUR OF DEATH

6-18-65

7:45 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3305 Marshall Court

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

6-9-94

9. AGE (In years
last birthday)

71

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Housework

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Ernest Schultz

14. MOTHER'S MAIDEN NAME

Donothesa ?

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18. 10391

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) Adenocarcinoma of Bowel with
DUE TO wide spread Metastasis.

1 Year

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-14-19 65 to 6-18-19 65,
that (I) (we) last saw the deceased alive on 6-18-19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

H. Rathbun

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6-18-65

23C. PHYSICIAN'S
NAME (Type)

Dr. Howard Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6-22-65

24C. NAME OF CEMETERY or CREMATORY

Schwartz Cemetery

24D. LOCATION

(City, town, or county)

(State)

6115 O'Donnell St. Balto. 24, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUN 21 1965

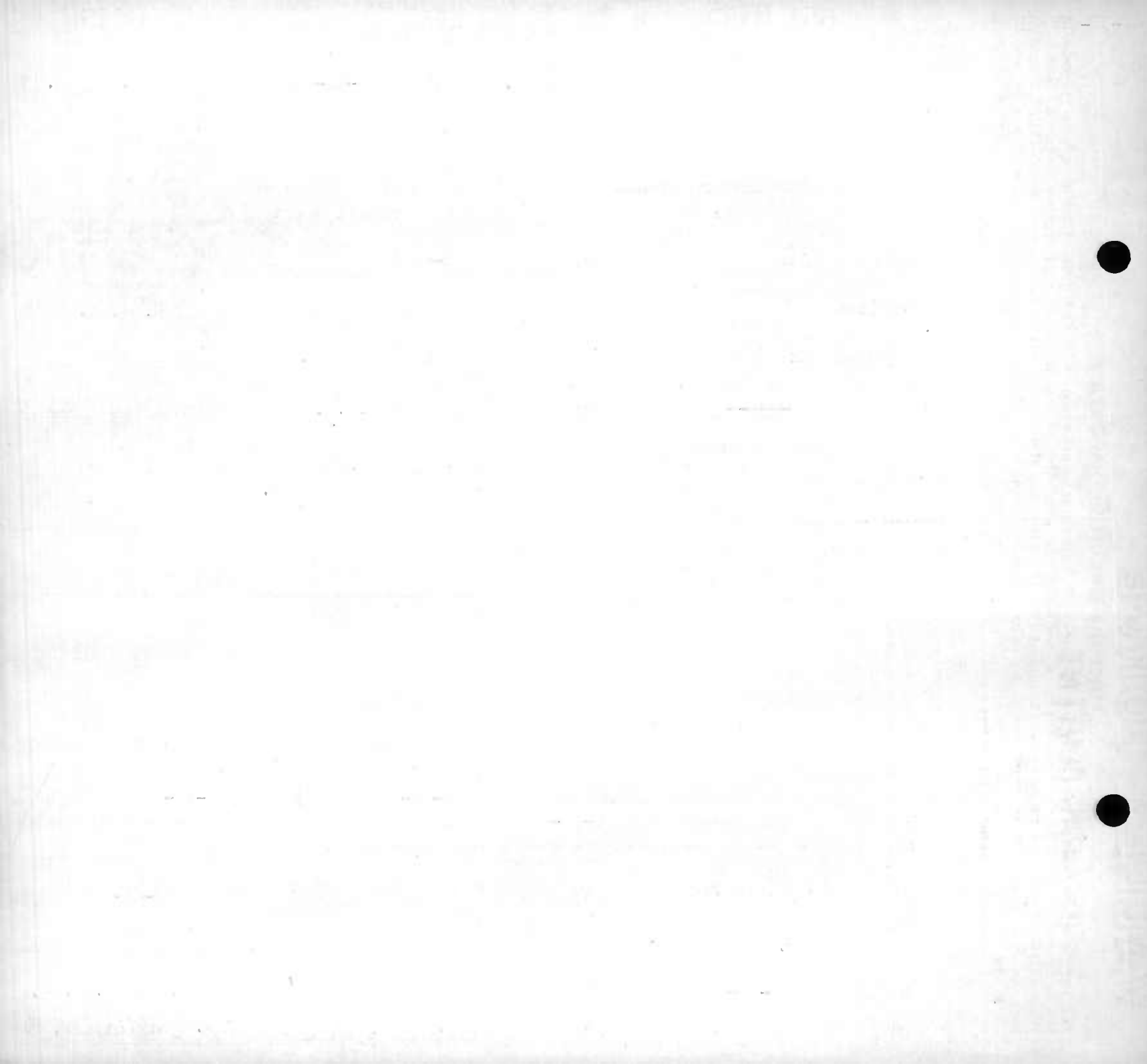
Robert E. Farley M.D.

Charles S. Geiler

901 S. Conkling St. #24

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

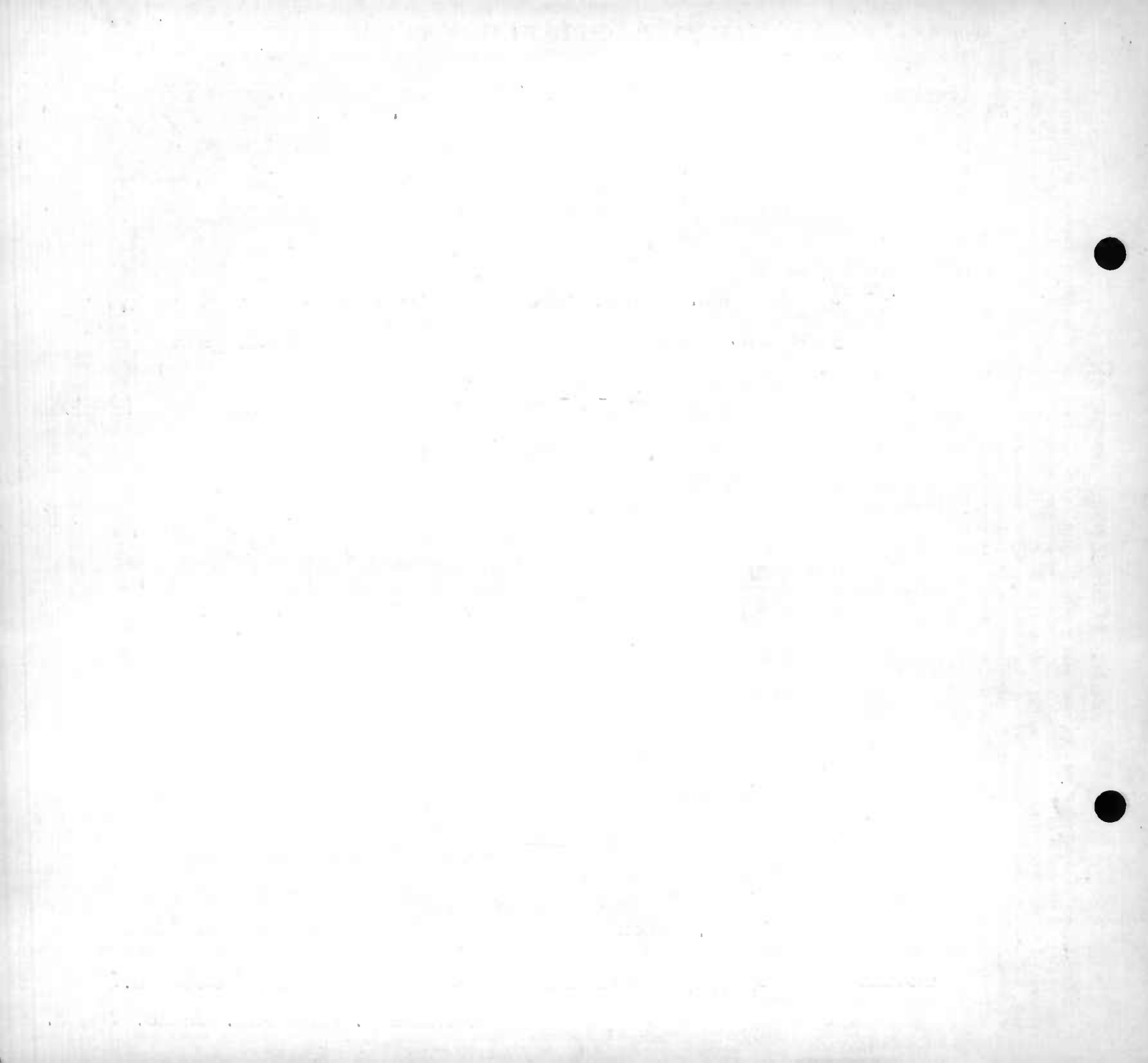
BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 6446	
BIRTH NO. 65-14558 65 6446					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
KOLACZ, MICHAEL JOSEPH		June 21, 1965		3:10 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital		A. STATE Md.			
(If not in hospital or institution, give street address or location)		B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 6			
		D. STREET ADDRESS (If rural, give location) 5001 Benton Heights Ave.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 6/21/65	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 2 19
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John J. Kolacz		14. MOTHER'S MAIDEN NAME Patricia A. Schiaffino	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ----		17. INFORMANT John J. Kolacz	
				ADDRESS same	
18. 762.5 I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Immaturity; atelectasis of lungs DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,		(B) _____ DUE TO			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 21 19 65 to June 21 19 65 , that (I) (we) last saw the deceased alive on June 21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Glorio G. Sagisi		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/21/65	
23C. PHYSICIAN'S NAME (Type) Glocrito G. Sagisi		23D. ADDRESS 1400 N. Caroline Street, 21213			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 6-22-65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR L. J. Ruck Inc.	
				ADDRESS Baltimore, Md.	

John W. Taylor

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6447		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6447	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>George Carroll Morey</i>		
2. DATE AND HOUR OF DEATH <i>6/20/65 12:45 A.M.</i>			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hosp</i>		(If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #36</i>		D. STREET ADDRESS (If rural, give location) <i>Maryland School for the Blind</i>			
5. SEX <i>m</i>	6. RACE <i>w</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>m</i>	8. DATE OF BIRTH <i>3-28-07</i>	9. AGE (In years last birthday) <i>58</i>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Md. School Blind</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>George W. Morey</i>		14. MOTHER'S MAIDEN NAME <i>Lillie Cash</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-07-3833</i>		17. INFORMANT ADDRESS <i>Wife - Leta B. Morey (Same)</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH <i>Status 1 year post right pneumo-ectomy for ca of lung & metastases to liver, mediastinum, erosion of the esophagus & perforation of mediastinitis, pericarditis & myocardial & right ventricular hypertrophy & dilatation. Chronic congestion of liver & generalized arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12:15 pm 6/20/65</i> to <i>12:45 am 6/20/65</i> , that (I) (we) last saw the deceased alive on <i>6/20/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Miriam R. Cohen</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/20/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Miriam R. Cohen</i>		23D. ADDRESS <i>Union Memorial Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/23/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Woodlawn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 21 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck Inc. Balto. 14 Md.</i>			



38-09-70

AM

65 6448

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 6448

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Harry Williams Jr.

2. DATE AND HOUR OF DEATH

6-20-65

6:00 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2930 Berwick Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11-19-13

9. AGE (In years
last birthday)

51

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Draftsman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Harry W. Williams Sr.

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

217-03-0315

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18.

722.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) Aortic Insufficiency
DUE TO(B) Ankylosing Spondylitis
DUE TO

20 Years

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Chylous Effusion in Pleura

6 Months

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-16-19 65 to 6-20-19 65,

that (I) (we) last saw the deceased alive on 6-20-65 19 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

C.C. Carpenter

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6-20-65

23C. PHYSICIAN'S
NAME (Type)

Dr. C. C. J. Carpenter

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/23/65

24C. NAME of CEMETERY or CREMATORY

Immanuel Lutheran Cem.

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 21 1965

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

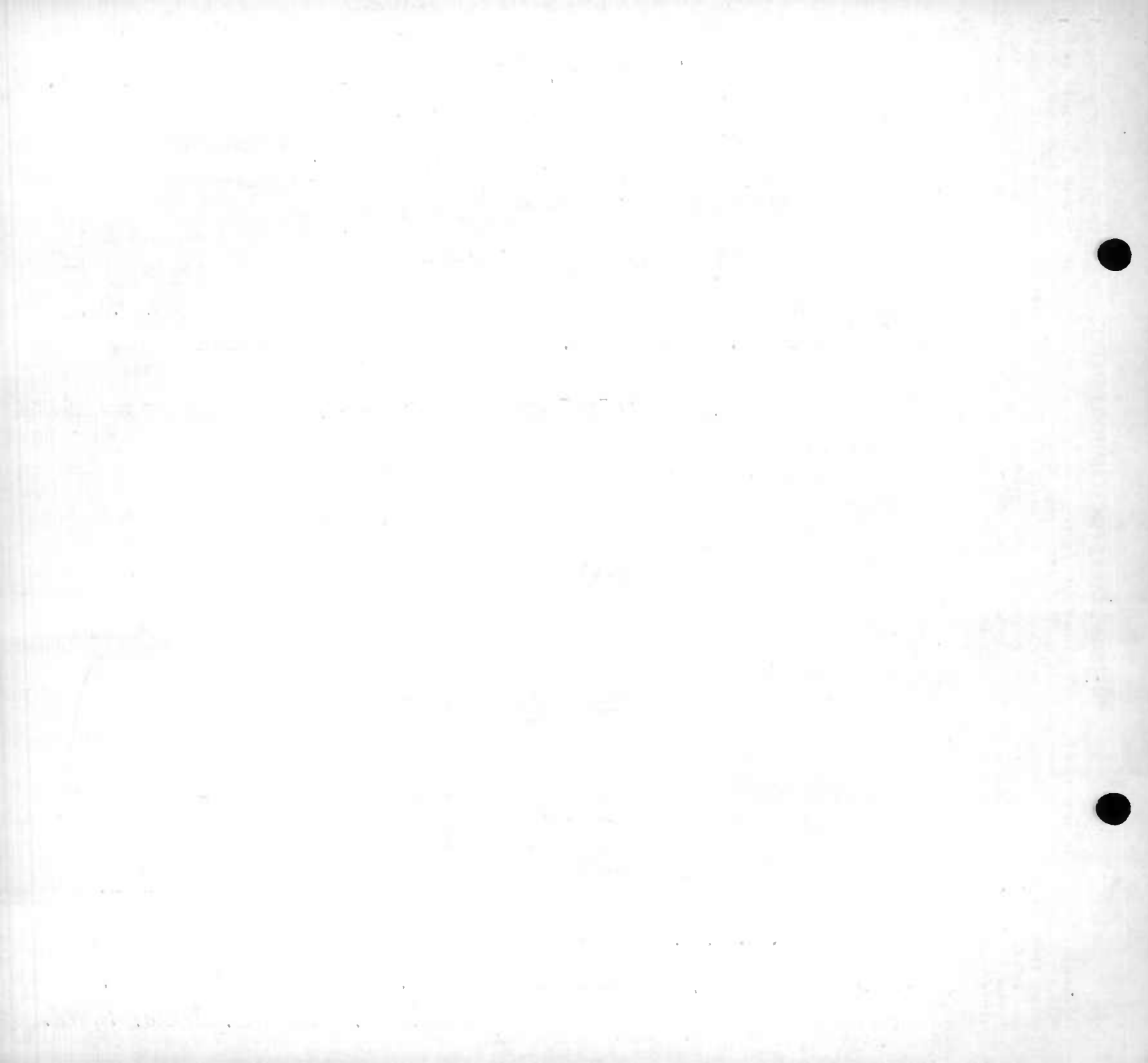
25C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto. 14 Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

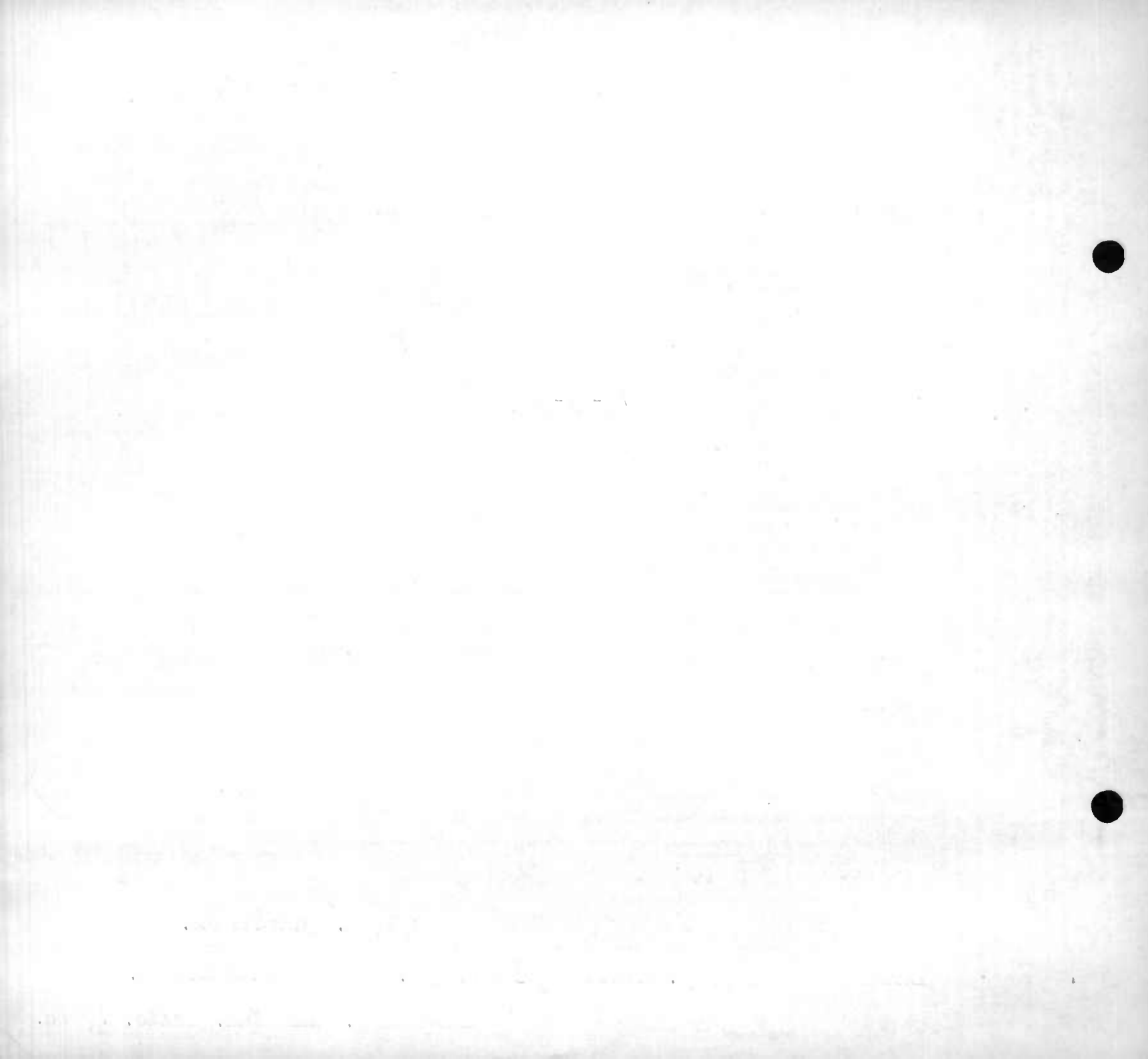
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6449		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6449	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) RAYMOND; Harry Sam		
2. DATE AND HOUR OF DEATH JUNE 20, 1965 4 Am			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			5. STATE Maryland		
6. CITY OR TOWN (If outside city limits, write RURAL and give township)			7. STREET ADDRESS (If rural, give location)		
8. CITY OR TOWN 2704 White Ave			9. STREET ADDRESS Baltimore 14 Md.		
10. SEX m	11. RACE w	12. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	13. DATE OF BIRTH 7-19-1913	14. AGE (In years lost birthday) 51	15. If Under 1 Yr. Months: Days: Hours: Min.
16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman		17. KIND OF BUSINESS OR INDUSTRY Beth Steel		18. BIRTHPLACE (State or foreign country) VA	
19. CITIZEN OF WHAT COUNTRY? USA		20. FATHER'S NAME Raymond Charles		21. MOTHER'S MAIDEN NAME Jennie	
22. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		23. SOCIAL SECURITY NO. 214-05-3137		24. INFORMANT Chart	
25. CAUSE OF DEATH			26. INTERVAL BETWEEN ONSET AND DEATH		
27. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			28. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		
29. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			30. MEDICAL CERTIFICATION		
31. DATE OF OPERATION 6-20-65		32. CONDITION FOR WHICH OPERATION WAS PERFORMED		33. AUTOPSY? (Yes or No)	
34. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		35. DATE OF OPERATION		36. CONDITION FOR WHICH OPERATION WAS PERFORMED	
37. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		38. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		39. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
40. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		41. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		42. HOW DID INJURY OCCUR?	
43. I certify that (I) (this hospital) attended the deceased from 6-17-65 to 6-20-65 and that (I) (we) last saw the deceased alive on 6-20-65 at 4:20 AM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
44. SIGNATURE Charles T. ... M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				45. DATE SIGNED 6-20-65	
46. PHYSICIAN'S NAME (Type) Marian Friedman M.D.				47. ADDRESS 2724 N. Charles St.	
48. BURIAL CREMATION, REMOVAL (Specify) Burial		49. DATE 6/23/65		50. NAME OF CEMETERY or CREMATORY Gardens Of Faith Cem.	
51. LOCATION (City, town, or county) Baltimore Md.		52. DATE REC'D BY HEALTH DEPT. JUN 21 1965		53. NAME OF REGISTRAR Robert E. Farley, M.D.	
54. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. 14 Md.		55. ADDRESS			



1
M-255

65 6450

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 6450

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CLARA McNAMARA

2. DATE AND HOUR PRONOUNCED DEAD

6/18/65 4:05 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore #14

D. STREET ADDRESS (If rural, give location)

5111 Harford Rd.

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

March 16, 1906

9. AGE (In years last birthday)

59

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Secretary

10B. KIND OF BUSINESS OR INDUSTRY

Medical

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Walter C. Curran

14. MOTHER'S MAIDEN NAME

Rosalene Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-28-3832

17. INFORMANT

ADDRESS

Mrs. Mary Rose Hoban 1372 Halstead St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK

NOT WHILE AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

6/19/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

6/22/65

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 21 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Leona rd J. Ruck Inc. Balto. 14 Md.

Wilmington, Md.

6/27/62. Col. Robert G. Gentry

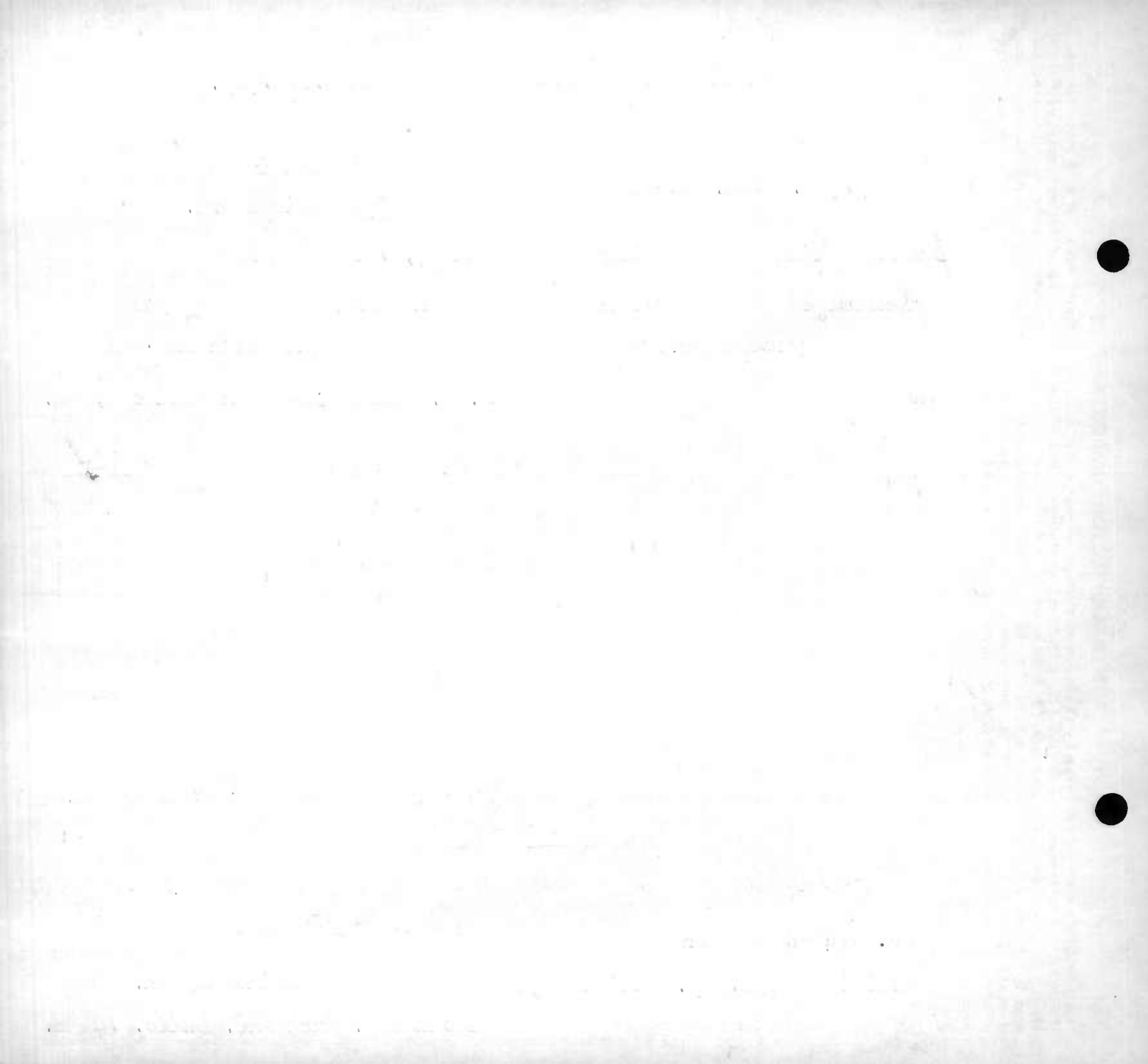
Serial

Exhibit 4. 1000 1000 1000 1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

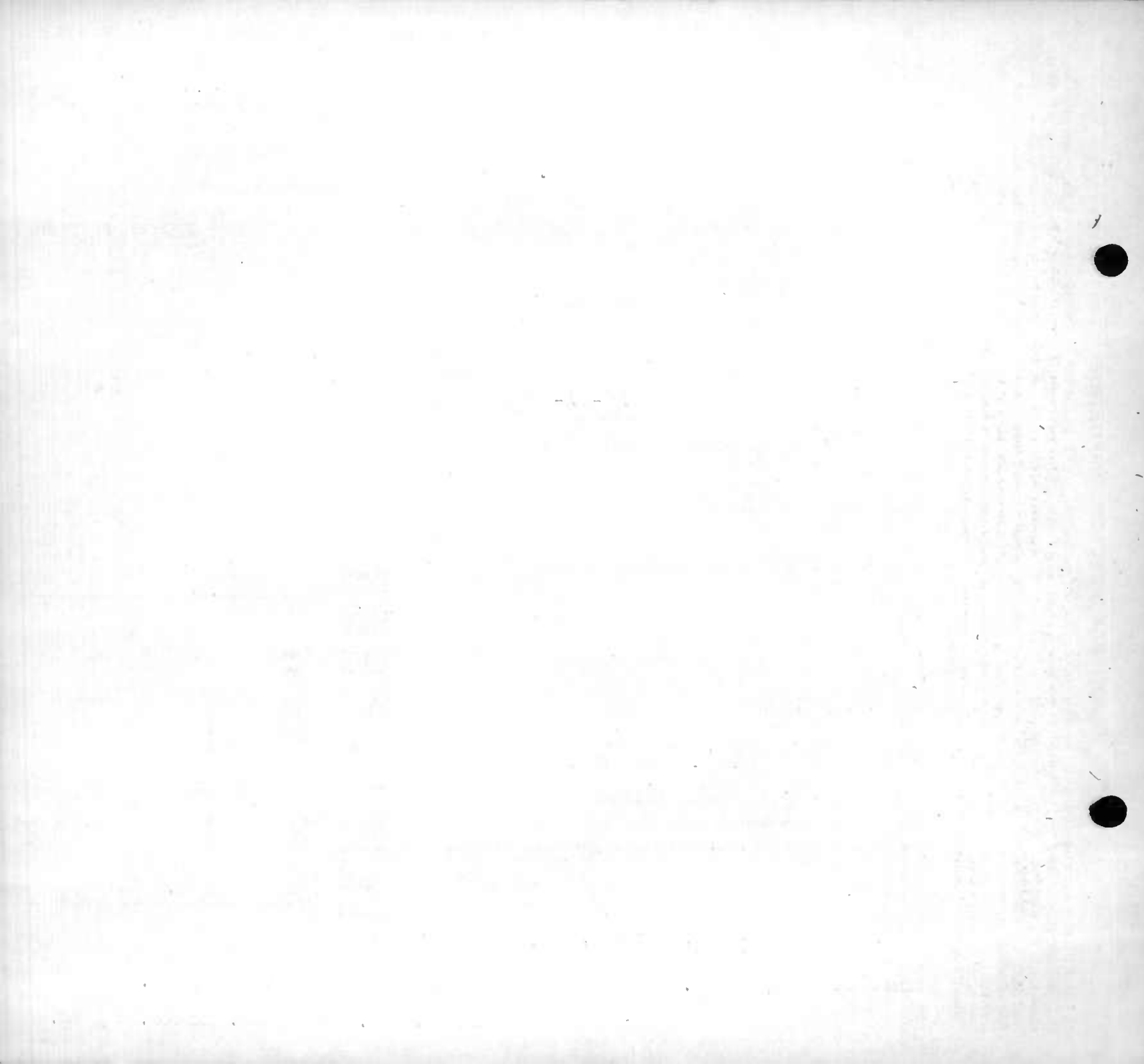
BIRTH NO. 65 6451		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6451	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Mattie Sue Johnson		June 18, 1965.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Md. B. COUNTY Balto	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
714 W. 36th. Street		Baltimore		7932 Bridge Ave.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	White	Widow	July 4, 1882	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Own Home		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
George Sullivan		Elizabeth Bankert		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Mr. D. Sylvan Friedman Balto 2, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Coronary Thrombosis DUE TO (B) generalized arteriosclerosis DUE TO (C) Cerebro-vascular accident		Sudden — 2 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 5 1965 to June 18 1965, that (I) (we) last saw the deceased alive on June 16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Reuben Hoffman				June 19, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Reuben Hoffman		846 W. 36th St			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		6/21/65		Kriders Cemetery	
24D. LOCATION (City, town, or county)		24E. NAME of REGISTRAR		24F. FUNERAL DIRECTOR ADDRESS	
Westminster, Md.				Leonard J. Ruck Inc. Balto. 14 Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 21 1965		R. E. E. Johnson		Leonard J. Ruck Inc. Balto. 14 Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 6452		CERTIFICATE OF DEATH		Registered No. 65 6452	
1. NAME OF DECEASED (Type or Print) THERESA MARY BEHR				2. DATE AND HOUR OF DEATH JUNE 18, 1965 1935 P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) # 6 D. STREET ADDRESS (If rural, give location) 4627 GREENHILL AVENUE					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 2/17/96		9. AGE (In years lost birthday) 69		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE LOCHNER				14. MOTHER'S MAIDEN NAME MARGARET STEINBERGER					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 215401-6095		17. INFORMANT ADDRESS HOSPITAL RECORDS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 332X1 MASSIVE INFARCTION OF MYO CARDIUM CAUSE OF DEATH (A) DUE TO cerebral hemisphere due to thrombosis of internal carotid & middle cerebral artery. (B) DUE TO old encephalomalacia, left internal capsule. (C) inactive rheumatic heart disease & calcific mitral stenosis. Thrombus left auricle. INTERVAL BETWEEN ONSET AND DEATH 3 days.				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II calcific mitral stenosis.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from JUNE 15 19 65 to JUNE 18 19 65 , that (I) (we) lost saw the deceased alive on JUNE 18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE William R. Linton, Jr.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/19/65			
23C. PHYSICIAN'S NAME (Type) William R. Linton, Jr.				23D. ADDRESS UNION MEMORIAL HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/22/65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto.			ADDRESS 14 Md.		



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 6453		65 6453	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		EMMA M. ROSSING		2. DATE AND HOUR OF DEATH 6/18/65 5:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
MERCY HOSPITAL				MARYLAND	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				BALTIMORE #4	
				D. STREET ADDRESS (If rural, give location)	
				602 HAMPTON CANE	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
F	W	SINGLE	1/5/1896	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
At Home		Own Home		BALTIMORE, Mo.	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
CHARLES A. ROSSING			USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or Unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			None		Mrs. Chas. B. Kelly Sr. (Same)
18. 541.0 1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) RESPIRATORY ARREST		Min	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) SCARRED DUODENUM		Yrs.	
ANTECEDENT CAUSES		(C)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
1/5/27/65					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from 5/21 1965 to 6/18 1965 that (we) last saw the deceased alive on 6/18 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
William S. Byers, M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				6/18/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
WILLIAM S. BYERS				MERCY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/21/65		Parkwood Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 21 1965		Robert E. Farley, M.D.		Leonard J. Rack Inc. Balto. 14 Md.	

8/2/65 - Operation - Vagotomy, gastrojejunostomy, gastrectomy
autopsy - Final anatomical diagnosis
Chronic Duodenal Ulcer with possible pyloric stenosis (history)
Ruled out Crohn's disease
No past myocardial infarction
Fully informed - information from history & physical - under 40 years of age.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

2. DATE AND HOUR PRONOUNCED DEAD

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Yes

Korean

285-28-5724

Bertha Stokes 1702 N. Broadway

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive cardiovascular disease,
~~XXXX~~ possibly associated with chronic
glomerulo-nephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Warner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

6/19/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Burial

6/27/65

Cleveland, Ohio

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 21 1965

Robert E. Farley, M.D.

Wm March 928 E. North Ave. Balto., Md.

VALLEY HOUSE

1/15/65 QUARTERS

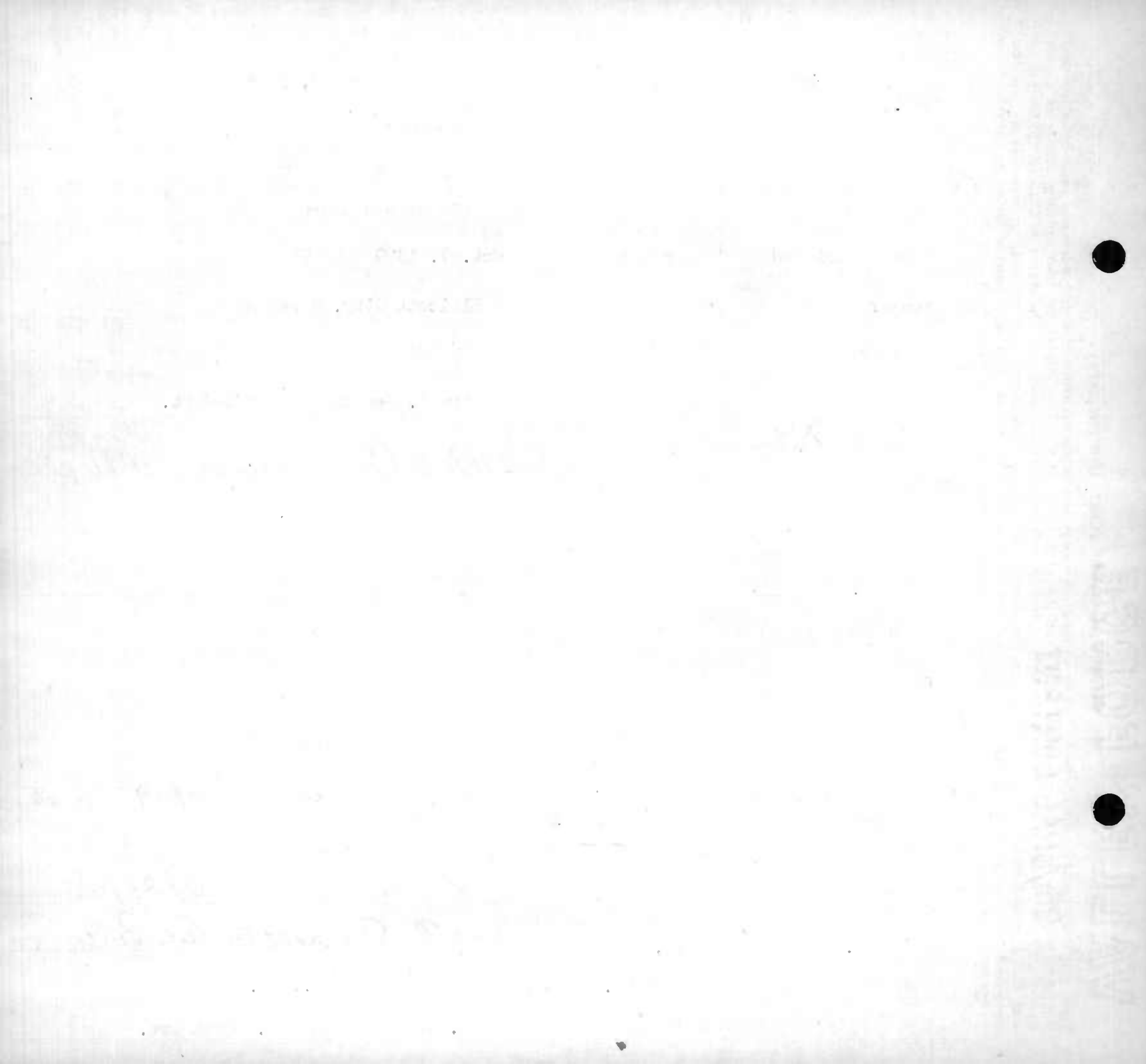
1. The following information was obtained from the records of the Valley House for the period 1/15/65 to 1/31/65.

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FUNERAL DIRECTOR: IMPORTANT

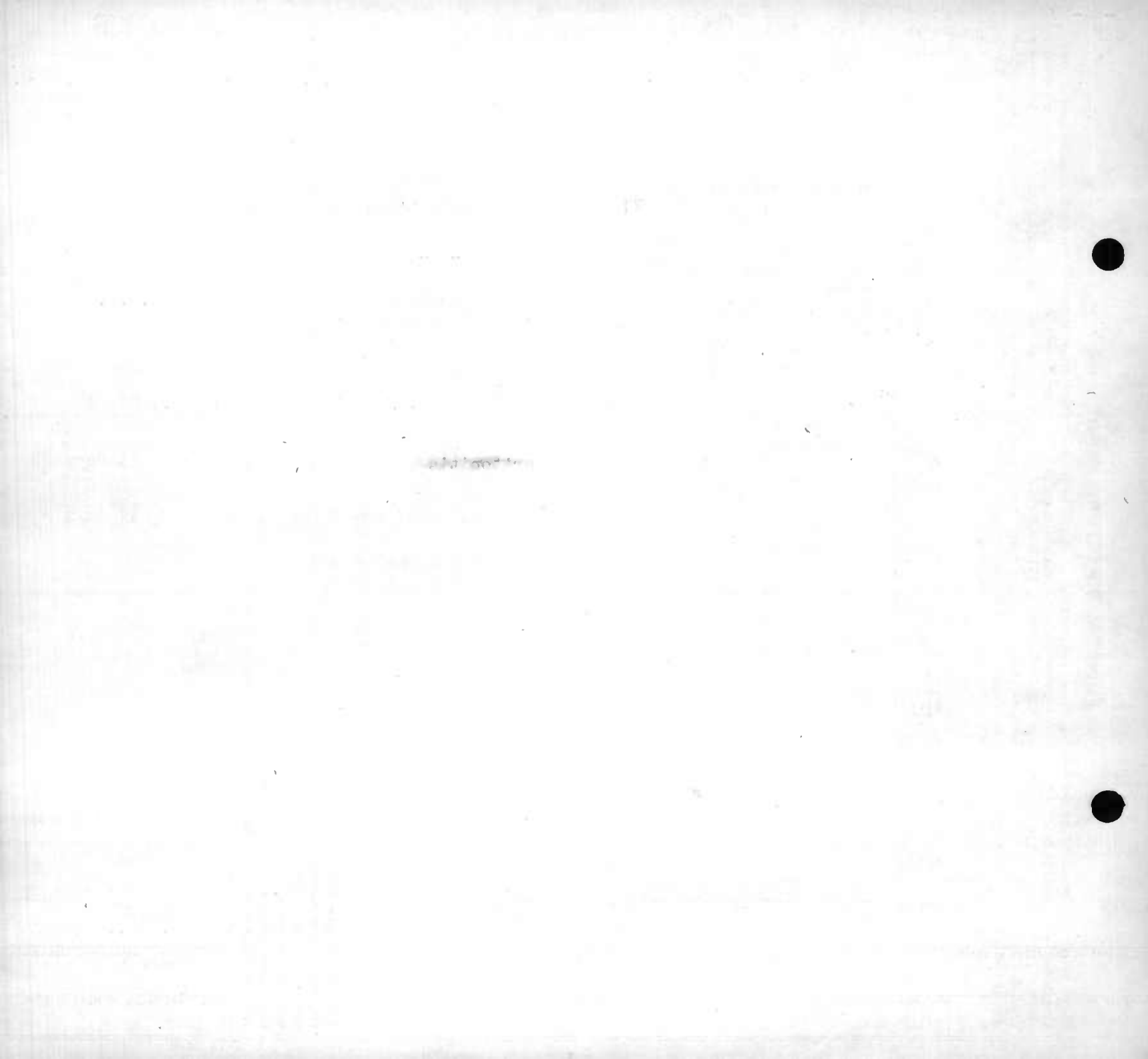
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 6455		CERTIFICATE OF DEATH		65 6455	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) James Emory Henson			2. DATE AND HOUR OF DEATH June 19, 1965 10:05 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 470 Oxford Court			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY 1184 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 470 Oxford Court		
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Oct. 7, 1890	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ellicott City, Maryland	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO.		17. INFORMANT Mary A. Henson 470 Oxford Ct.	
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ASHD - Cong. Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) ASHD - Cong. Failure DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 11 months		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/6/64 to 6/19/65 , that (I) (we) last saw the deceased alive on 6/5/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.					
23A. SIGNATURE  J. Preston Grant				23B. DATE SIGNED 6/21/65	
23C. PHYSICIAN'S NAME (Type) J. Preston Grant		23D. ADDRESS 601 N. Carrollton Ave. Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/23/65		24C. NAME of CEMETERY or CREMATORY Balto. National Cemetery	
24D. LOCATION Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965			
25B. NAME OF REGISTRAR Robert E. Fairley		25C. FUNERAL DIRECTOR A. Halstead 1206 W. North Ave.			



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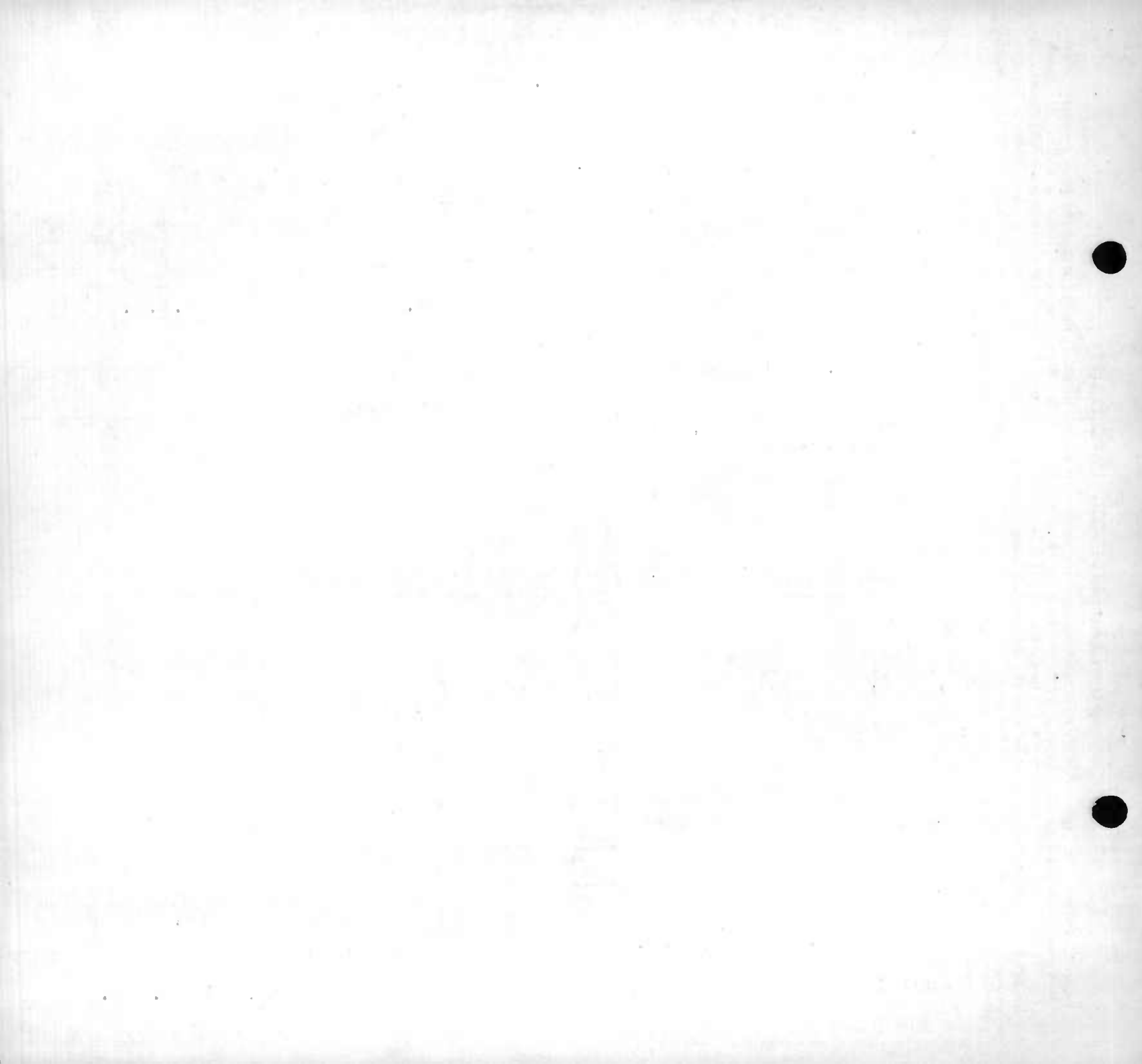
BIRTH NO.		65 6456		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6456	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) William Elsworth Smith			
2. DATE AND HOUR OF DEATH June 15, 1965 4:26 P.M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland, 21224			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore				5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single			
8. DATE OF BIRTH 7-15-1927				9. AGE (In years last birthday) 37		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman Cemetery				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland, Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Charles Wm. Smith			
14. MOTHER'S MAIDEN NAME Mamie Porter				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 217221391				17. INFORMANT ADDRESS RECORDS: BCH, 4940 Eastern Ave., 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) Peritonitis				INTERVAL BETWEEN ONSET AND DEATH 11 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Perforation of Small Intestine DUE TO				11 days			
(C) Idiopathic Patchy Necrosis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Alcoholism				20 years			
19A. DATE OF OPERATION 3 13 June 65				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforation of Small Intestine		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 11, 19 65 to June 15, 19 65, that (I) (we) last saw the deceased alive on June 15, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Donald Baltzan				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 15, 1965	
23C. PHYSICIAN'S NAME (Type) DONALD BALTZAN				23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Md., #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/19/65		24C. NAME of CEMETERY or CREMATORY Saint Matthews Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS Henry Sander & Sons Inc. Baltimore, Maryland			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6457		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6457	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Benjamin A. Neal		JUNE 19, 1965 1 00 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL BALTIMORE 5, MD		MARYLAND ANNE ARUNDEL			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		52-00	
		D. STREET ADDRESS (If rural, give location)			
		RT 2 BOX 77			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	B. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
M	NEGRO	WIDOWED	10 - 10 - 94	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			Va.		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOHN W. NEAL			HARRIET OFFER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No			Carrie Watkins		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(A) PULMONARY Abscess + PNEUMONIA			6 mon
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
6-17-65		PULMONARY Abscess + Consolidation		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6-10 19 65 to 6-19 19 65, that (I) (we) last saw the deceased alive on 6-19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John D. Harrah, M.D.				6-19-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JOHN D. HARRAH, M.D.		THE JOHNS HOPKINS HOSPITAL BALTIMORE, 5, MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		6/23/65		Chews Chaple	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 21 1965		Robert E. Farley		George H. Kiker 1348 N. Calhoun St	



65 6458

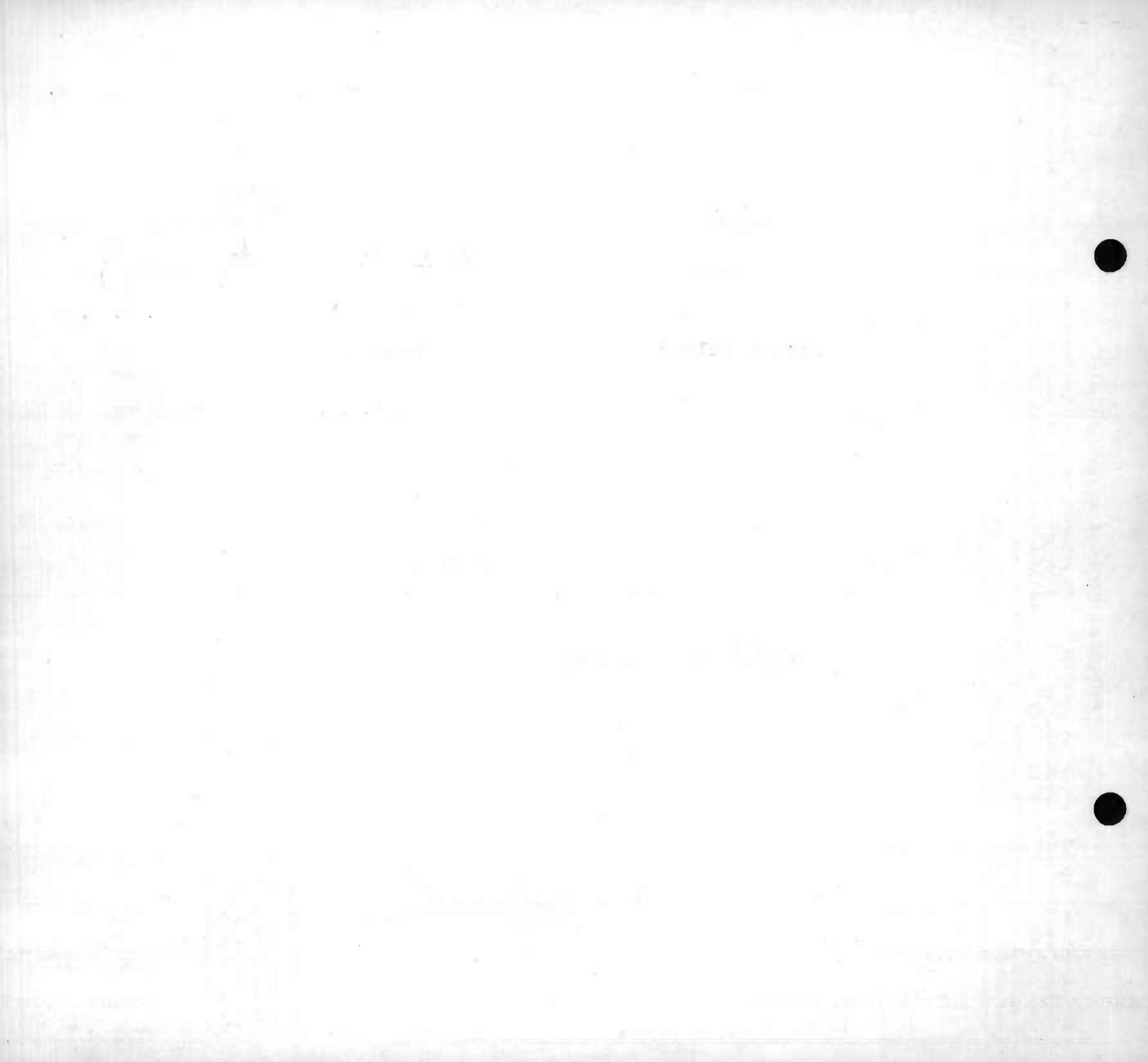
CERTIFICATE OF DEATH

Registered No. 65 6458

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

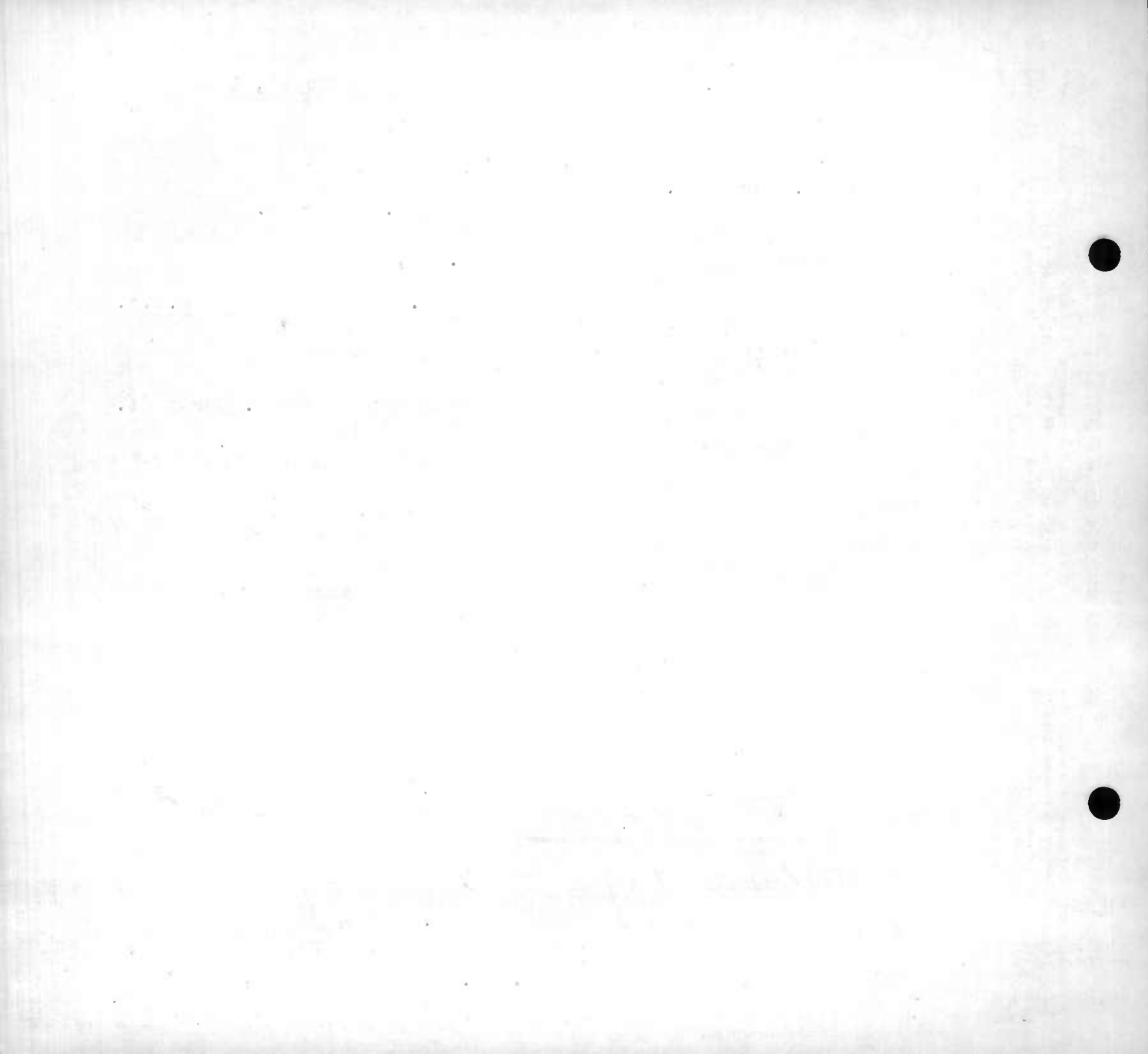
BIRTH NO. 65 6458		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6458	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Joseph Wilson			6-19-65 5:53 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224			A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1123 North Carey Street		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH # 3/22/15	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Preston Wilson			
14. MOTHER'S MAIDEN NAME Mammie Bailey				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS RECORDS: B.C.H. 4940 Eastern Avenue #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of Pharynx (Squamous Cell) (B) Pneumonia (C) Metastasis to Lungs			INTERVAL BETWEEN ONSET AND DEATH ? 2 Years 2 Weeks ?		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED (B) Above		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-9-19 65 to 6-19-19 65, that (I) (we) last saw the deceased alive on 6-19-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. R. Patterson				23B. DATE SIGNED 6-19-65	
23C. PHYSICIAN'S NAME (Type) W. R. PATTERSON				23D. ADDRESS 4940 Eastern Avenue #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-23-65		24C. NAME OF CEMETERY or CREMATORY Not Lutheran Cem.	
24D. LOCATION Baltimore, Md.		24E. STATE Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Farber, MA		25C. FUNERAL DIRECTOR George A. Kuhn 1348 N. Calton St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

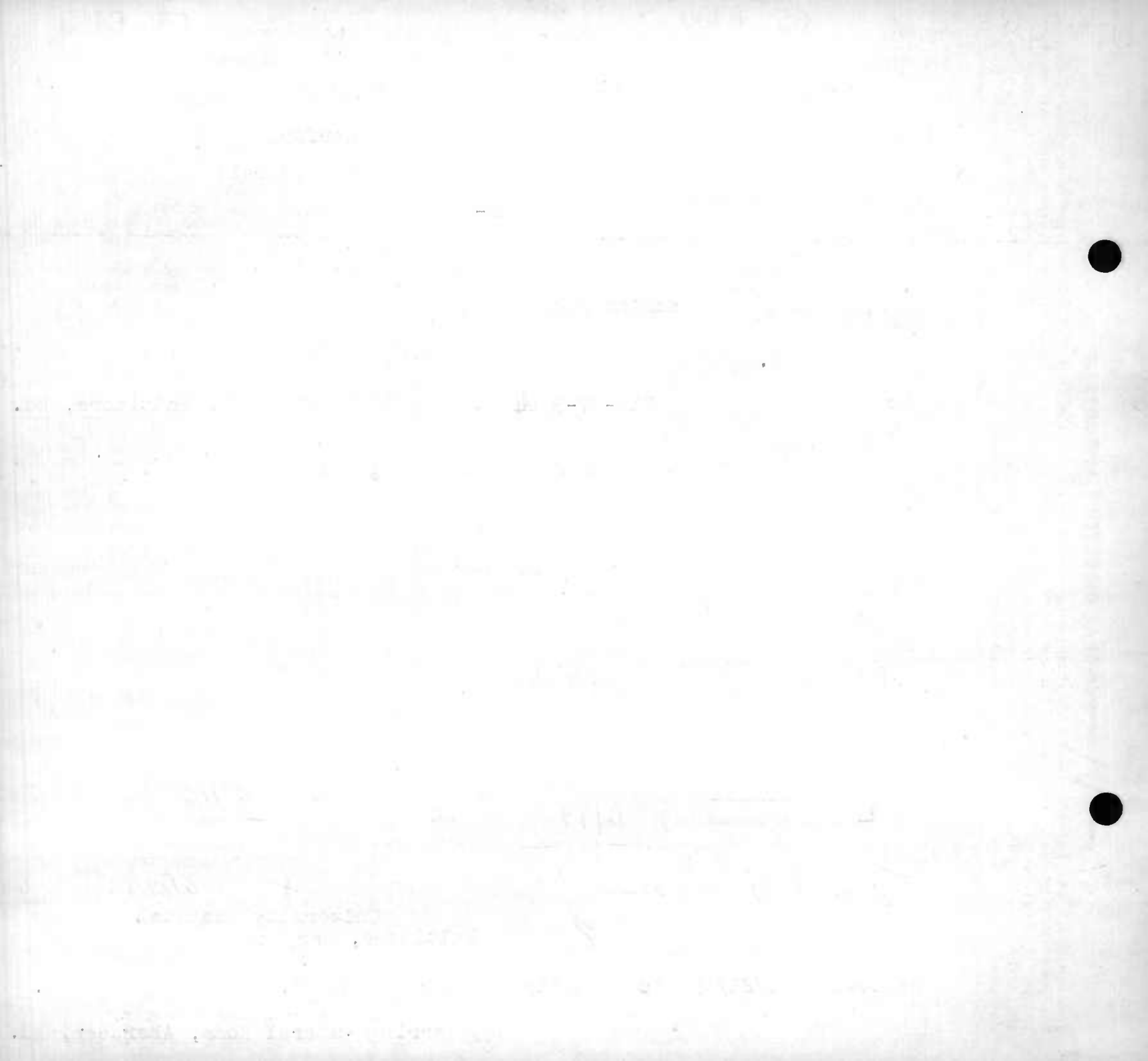
BIRTH NO. 65 6459				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6459	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Bertha E. Mason				2. DATE AND HOUR OF DEATH June 18, 1965			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 16-01			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 909 N. Carey St.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 909 N. Carey St.			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Feb. 27, 1905	9. AGE (In years last birthday) 60	If Under 1 Yr. Months	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Sorrell				14. MOTHER'S MAIDEN NAME Lucy Madden			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Frank Mason		ADDRESS 909 N. Carey St.	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I DIABETES MELLITUS 13 YRS							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II CARDIO VASCULAR DISEASE 3 YRS							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MAR 1 1962 to JUNE 18 1965. that (I) (we) last saw the deceased alive on JUNE 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. William Frey				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED JUNE 21/65	
23C. PHYSICIAN'S NAME (Type) E. WILLIAM FREY				23D. ADDRESS 1928 PENNA AVE BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/21/65		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.		24D. LOCATION (City, town, or county) (State) Arbutus, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 21 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR George H. Kilan		ADDRESS 1348 N. Calhoun St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 6460		CERTIFICATE OF DEATH		65 6460	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		ANDREW CURTIS HOWELL		6/19/65 1 8:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
UNIVERSITY HOSPITAL		MD.		Harford	
		C. CITY OR TOWN		(If outside city limits, write RURAL and give township)	
		JOPPA		(Rural) 62-00	
		D. STREET ADDRESS		(If rural, give location)	
		Box-622		MAGNOLIA ROAD	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
MALE	WHITE	MARRIED	9-17-14	50	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
machinist		Machine Shop		Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
EVERETT S. HOWELL		ETHEL HILTON		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		219-07-3564		hospital chart	
				ADDRESS	
				Baltimore, Md.	
18. 420.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Myocardial Infarction		-	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO			
		(C) ASCVD		Dysen	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
1/6/14		PVD, Sympathectomy			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		6/3		1965 to 6/19	
that (I) (we) last saw the deceased alive on		6/19		1965 and that in (my) (our) opinion death occurred on the date	
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Edward A. Pensen				6/19/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		University Hospital			
		Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Removal		6/21/65		Boyd Family Cemetery	
				Stuart, Va.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 22 1965		Robert E. Farkner		Tarring Funeral Home, Aberdeen, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6461				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6461	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Barbara J. Monat</i>				2. DATE AND HOUR OF DEATH <i>6-18-65</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>6210 - Everall Ave Baltimore 21206 - Md</i>				A. STATE <i>Maryland</i> B. COUNTY <i>27-34</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 21206</i>			
				D. STREET ADDRESS (If rural, give location) <i>6210 - Everall Ave.</i>			
5. SEX <i>F</i>	6. RACE <i>W.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>2/15/1874</i>	9. AGE (In years last birthday) <i>91 years</i>	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Mlynaric</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>V. J. Monat - son</i>		ADDRESS <i>Md 6210 - Everall Ave - Baltimore 21206</i>	
18. <i>7-20-11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>Myocardial Infarction</i> DUE TO (B) <i>Arteriosclerotic Heart Disease</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>6 hours</i> <i>30 years</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Dec. 24 1958</i> to <i>June 18 1965</i> , that (I) (we) last saw the deceased alive on <i>June 18 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Adam G. Swiss</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>June 21, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>ADAM G. SWISS</i>				23D. ADDRESS M.D. <i>6232 Belair Road, Balto. 6, Md</i>			
24A. BURIAL OR CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/21/65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Moulton Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 22 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Earl B. Woberton Funeral Home Inc. 6306 - Belair Rd, Baltimore 21206, Md</i>			

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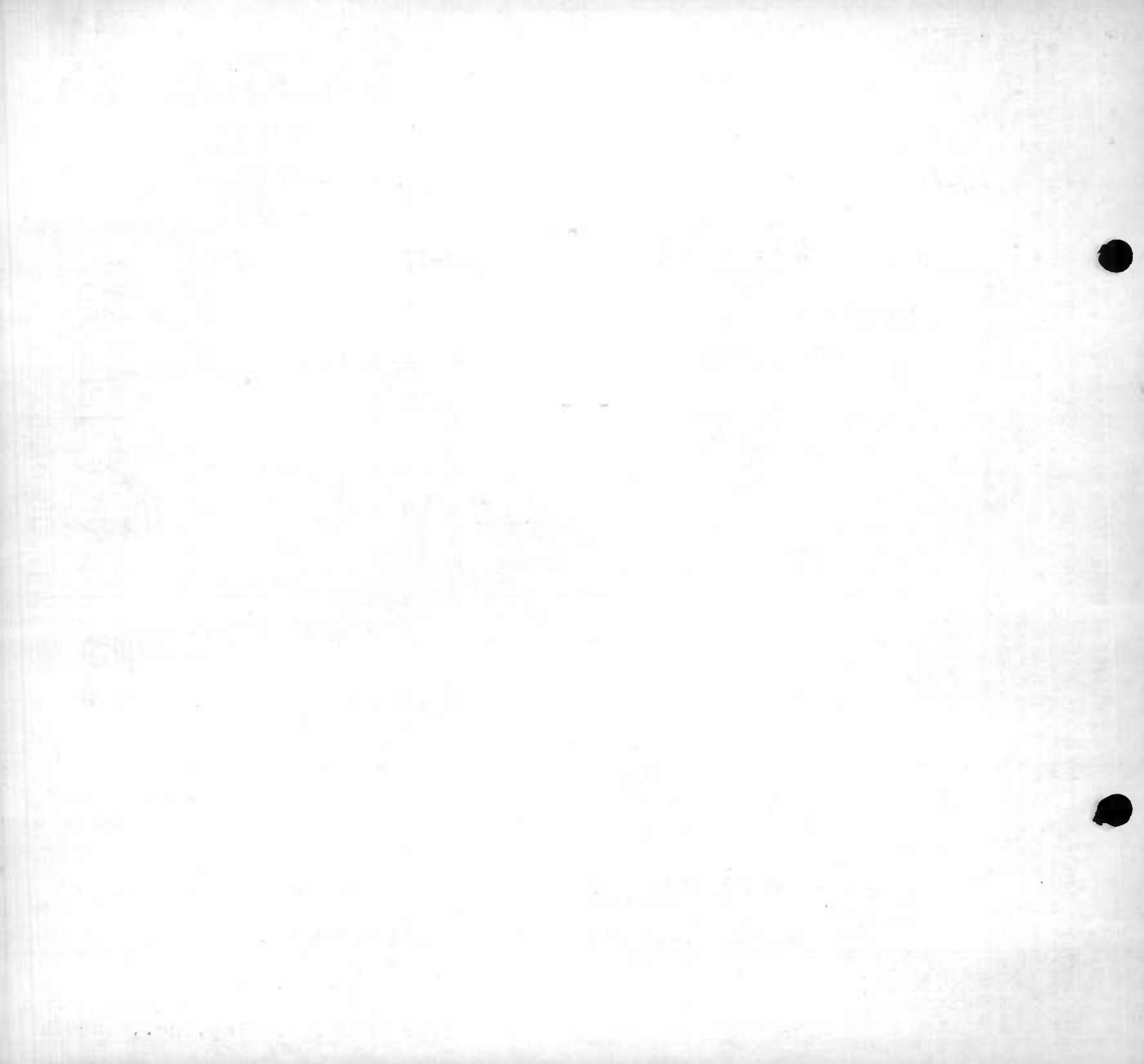
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6462	
BIRTH NO. Y 65 6462		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Elta Blancha TANNER		2. DATE AND HOUR OF DEATH 19 June 65 7 30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hosp.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk 21222 5300 D. STREET ADDRESS (If rural, give location) 6730 WOODLEY ROAD		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 6-1-77	9. AGE (In years lost birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME WARNER BEANE Beahn			14. MOTHER'S MAIDEN NAME FRANCES GAINES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 224-03-3565		17. INFORMANT ADDRESS Dorothy Blosser same as #4	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 602 X 14260 X Overwhelming sepsis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pyelonephritis & renal stone Renal			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 6 hr 43 hr
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Diabetes melitus					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 June 1965 to 19 June 1965 , that (I) (we) last saw the deceased alive on 19 June 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George M. Cullard M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 19 June 65	
23C. PHYSICIAN'S NAME (Type) GEORGE M. CULLARD				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/23/65		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial	
				24D. LOCATION (City, town, or county) (State) Dorsey, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 22 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS Walter Brooks Bradley, Inc., Dundalk	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6463		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6463	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Jones Harry Swope</i>		2. DATE AND HOUR OF DEATH <i>6/16/65 1:54⁴⁰ P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>8-05</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 13</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>24 Bon Secours Hosp.</i>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>1645 E. North Avenue</i>	
5. SEX <i>M</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>10-13-87</i>	9. AGE (In years lost birthday) <i>76</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Owner-operator</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>John D. Jones</i>		14. MOTHER'S MAIDEN NAME <i>Cordelia Hammond</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Alma Lushbaugh 31 1/2 E Franklin St. Hagerstown Md.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>acute coronary infarction days</i> (B) <i>congestive heart failure years</i> (C) <i>arteriosclerosis vasculi hearts. years</i>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-6</i> 196 <i>5</i> to <i>6-16</i> 196 <i>5</i> , that (I) (we) last saw the deceased alive on <i>6-16-65</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jaime Perea</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6-16-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>JAIME PEREA</i>		23D. ADDRESS <i>Bon Secours Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/20/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Fairmont Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Liberty town Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 22 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>	
25C. FUNERAL DIRECTOR <i>West Haver Funeral Chapel, Inc.</i>		25D. ADDRESS <i>James E. Towles, Jr.</i>			

Owner-operator Hotel

No

U.S.A.

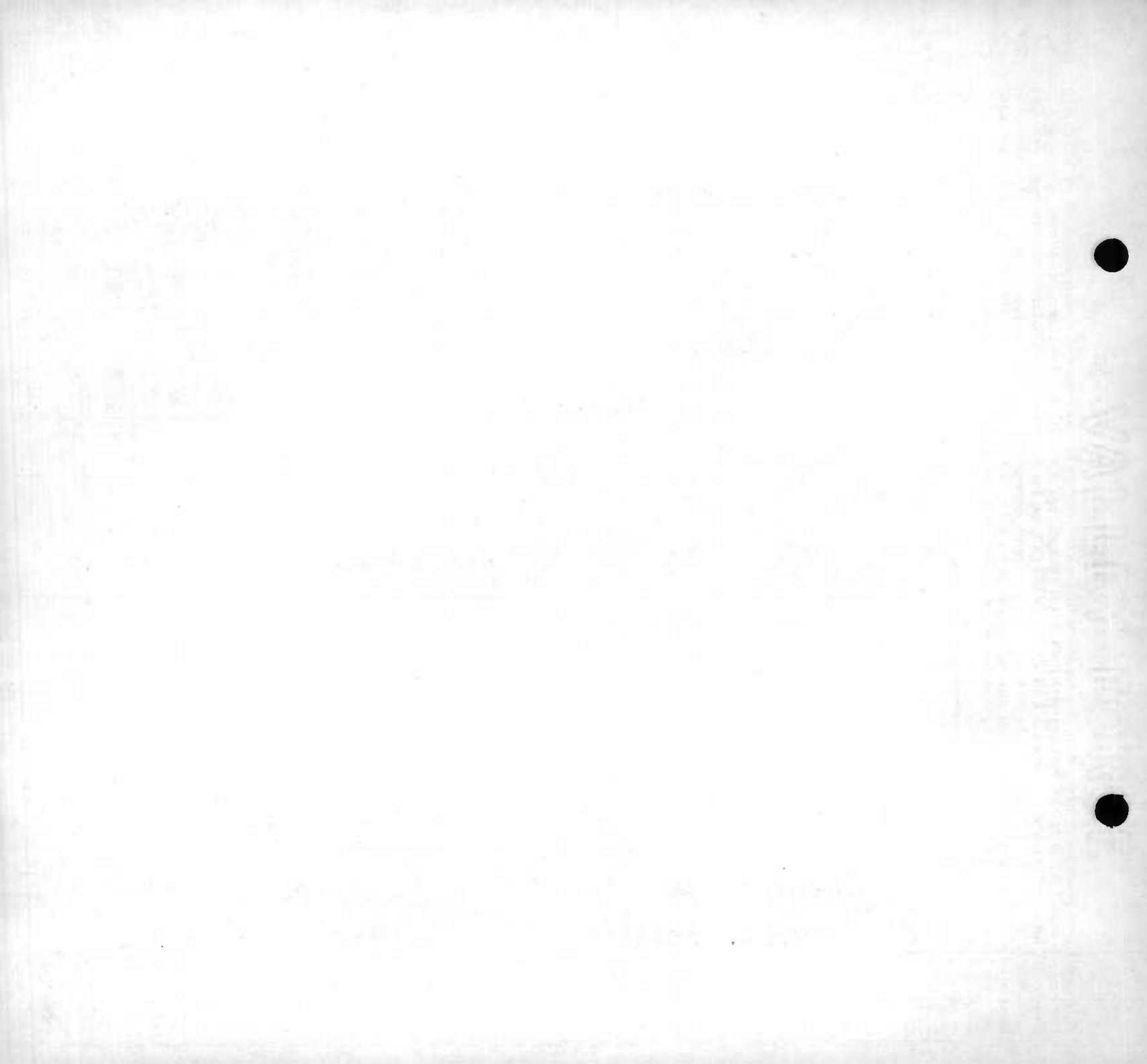
Alton (Lambert) 21.12.1941
Hofen (Lambert) 21.12.1941

General Electric, Fairmont Cemetery, Liberty, Iowa

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6464		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6464	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Ball, Dorothy H.		2. DATE AND HOUR OF DEATH 18 June 65 8 ³⁹ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Montebello State Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 33-00 D. STREET ADDRESS (If rural, give location) 1420 N. Rolling Rd.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 9/12/25	9. AGE (In years last birthday) 39	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Charles Hahn		14. MOTHER'S MAIDEN NAME Edith Mitchell		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 219-10-1819		17. INFORMANT Richard Ball		ADDRESS 1420 N. Rolling Rd.	
18. 193.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) cardiac arrest (B) intracranial pressure (C) glioblastoma		INTERVAL BETWEEN ONSET AND DEATH 12 mo.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/16/65 to 6/18/65, that (I) (we) last saw the deceased alive on 6/18/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Robert W. Ireland M.D.		23B. DATE SIGNED 6/18/65		23C. PHYSICIAN'S NAME (Type) Robert W. Ireland M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-21-1965		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore - Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 22 1965			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Edus. Mac Nabb - Catonsville - Md			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6465		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6465	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No. 65 6465	
1. NAME OF DECEASED (Type or Print) WRZESINSKI, EDWARD J		2. DATE AND HOUR OF DEATH JUNE 19, 1965		6:00AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL BALTO. 29, MD.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL C. CITY OR TOWN SEVERN (If outside city limits, write RURAL and give township) 62-00 D. STREET ADDRESS (If rural, give location) BOX 67B ROUTE 2			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-27-1914	9. AGE (in years last birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		10B. KIND OF BUSINESS OR INDUSTRY MASONRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME STANLEY WRZESINSKI		14. MOTHER'S MAIDEN NAME AGNES JASKULSKI (DEC'D)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216 03 7624		17. INFORMANT MRS. FRANCES WRZESINSKI (WIFE) SAME AS ST. AGNES RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Extensive malignant tumor of Brain DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from JUNE 6 19 65 to JUNE 19 19 65, that (I) (we) last saw the deceased alive on JUNE 19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Edilberto R. Beltran M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23B. DATE SIGNED 6/19/65		23C. PHYSICIAN'S NAME (Type) EDILBERTO R. BELTRAN M.D.		23D. ADDRESS St. Agnes Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JUNE 22/65		24C. NAME OF CEMETERY or CREMATORY GLEN HAVEN MEMORIAL PK, GLEN BURNIE, MARYLAND	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JUN 22 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR R.V. SINGLETON, GLEN BURNIE, MD.		25D. ADDRESS		25E. ADDRESS	

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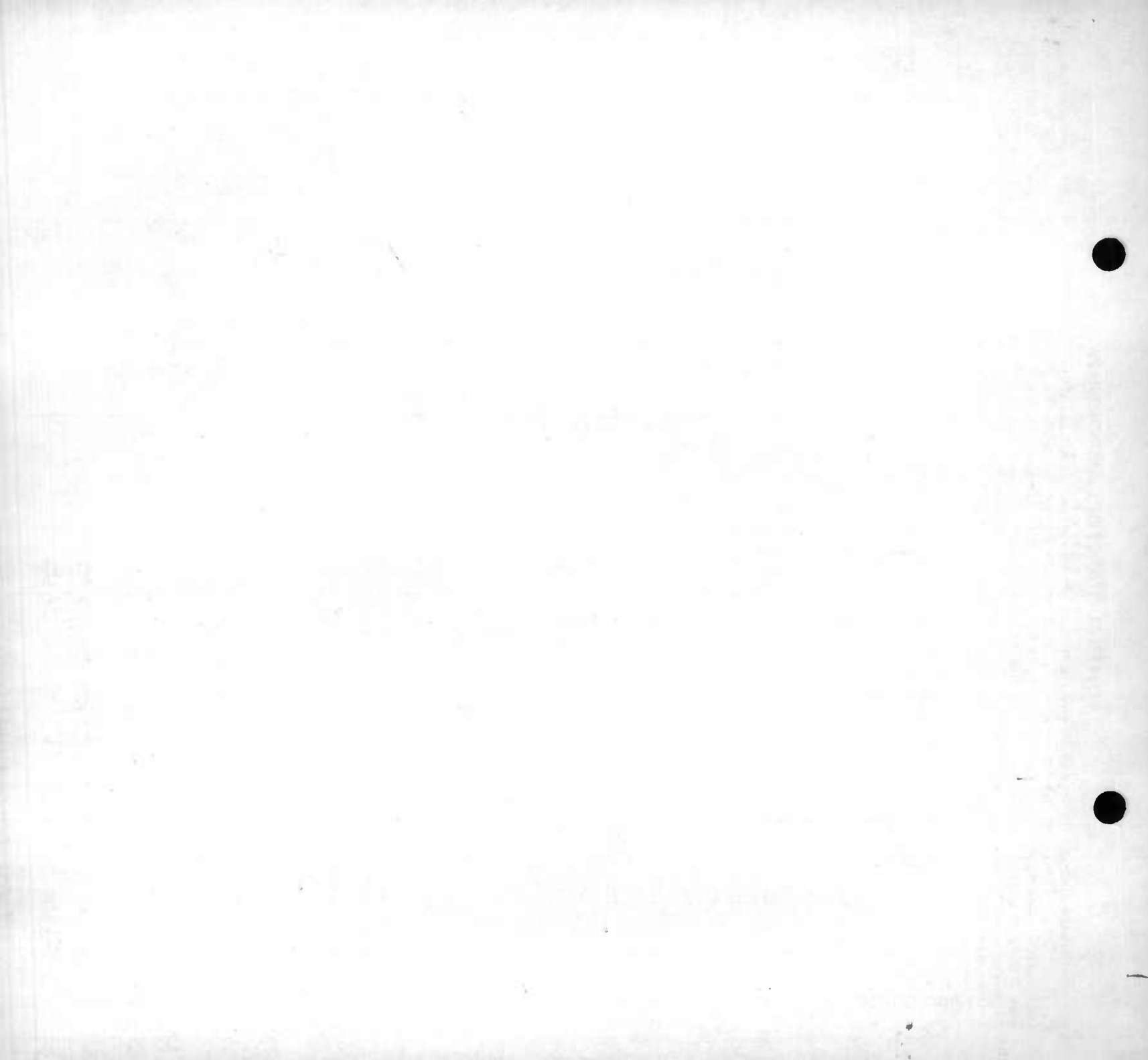
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

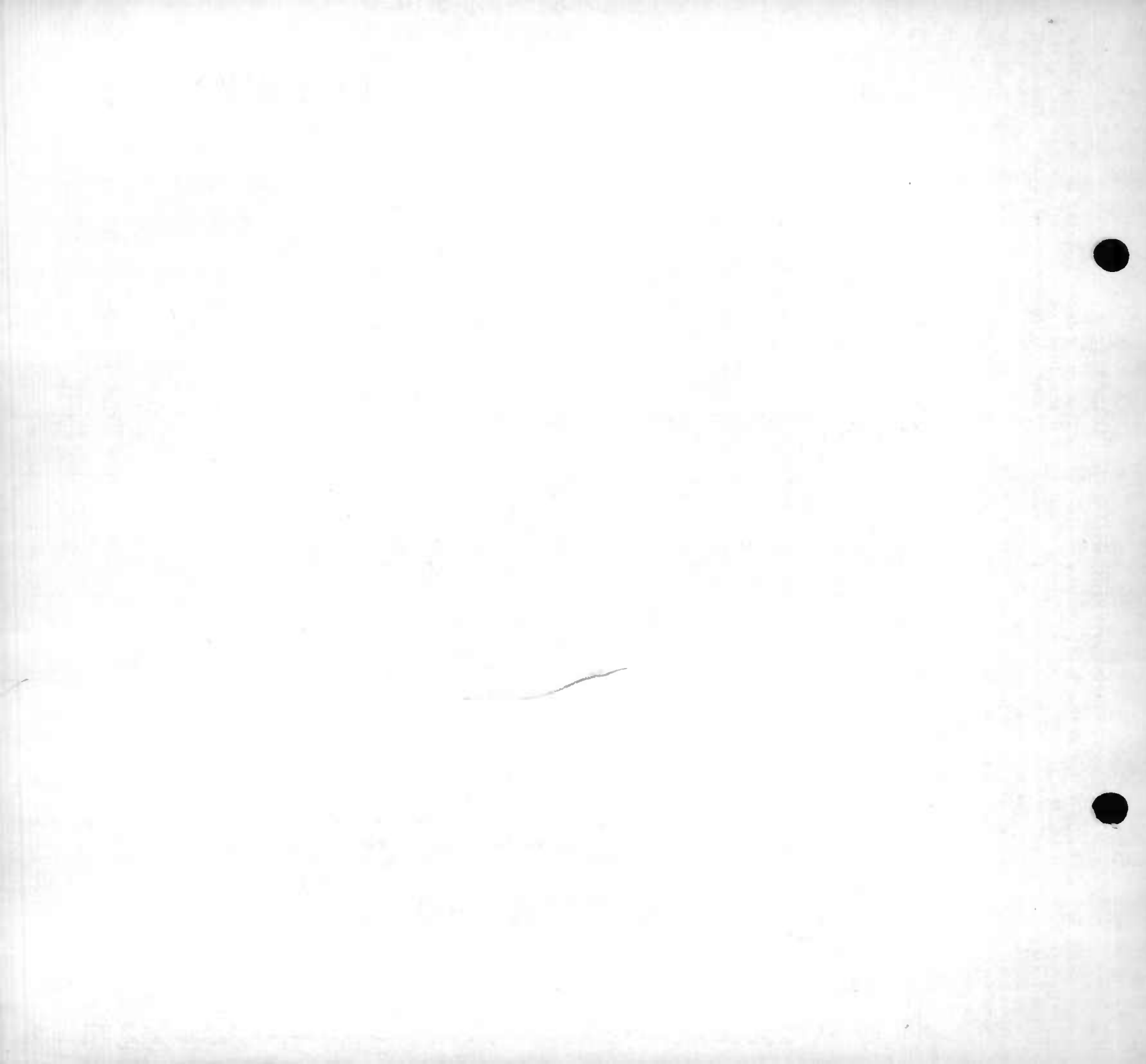
BIRTH NO. 65 6466				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6466	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Julia Desch</u>				2. DATE AND HOUR OF DEATH <u>6.20.65</u> <u>5P</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>				A. STATE <u>MD.</u> B. COUNTY <u>21-02</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>1131 Nanticoke St. #30</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>7/7/17</u>	9. AGE (In years last birthday) <u>47</u>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Henry Kucher</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Rudy</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>Hospital Chart</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) DUE TO <u>Acute Myocardial Infarct</u> (B) DUE TO <u>Generalized Arteriosclerosis severe</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>20 MIN</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Metrorrhagia for 6 weeks</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 19 1965</u> to <u>June 20 1965</u> , that (I) (we) last saw the deceased alive on <u>June 20 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>D. Lindenstein MD</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6.20.65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Daniel Lindenstein MD</u>				23D. ADDRESS <u>University Hosp. Balto. Md</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-23-65</u>		24C. NAME of CEMETERY or CREMATORY <u>Glen Haven</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 22 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkner</u>		25C. FUNERAL DIRECTOR <u>John J. Cowan & Son Inc</u>		ADDRESS <u>Balto. Md</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

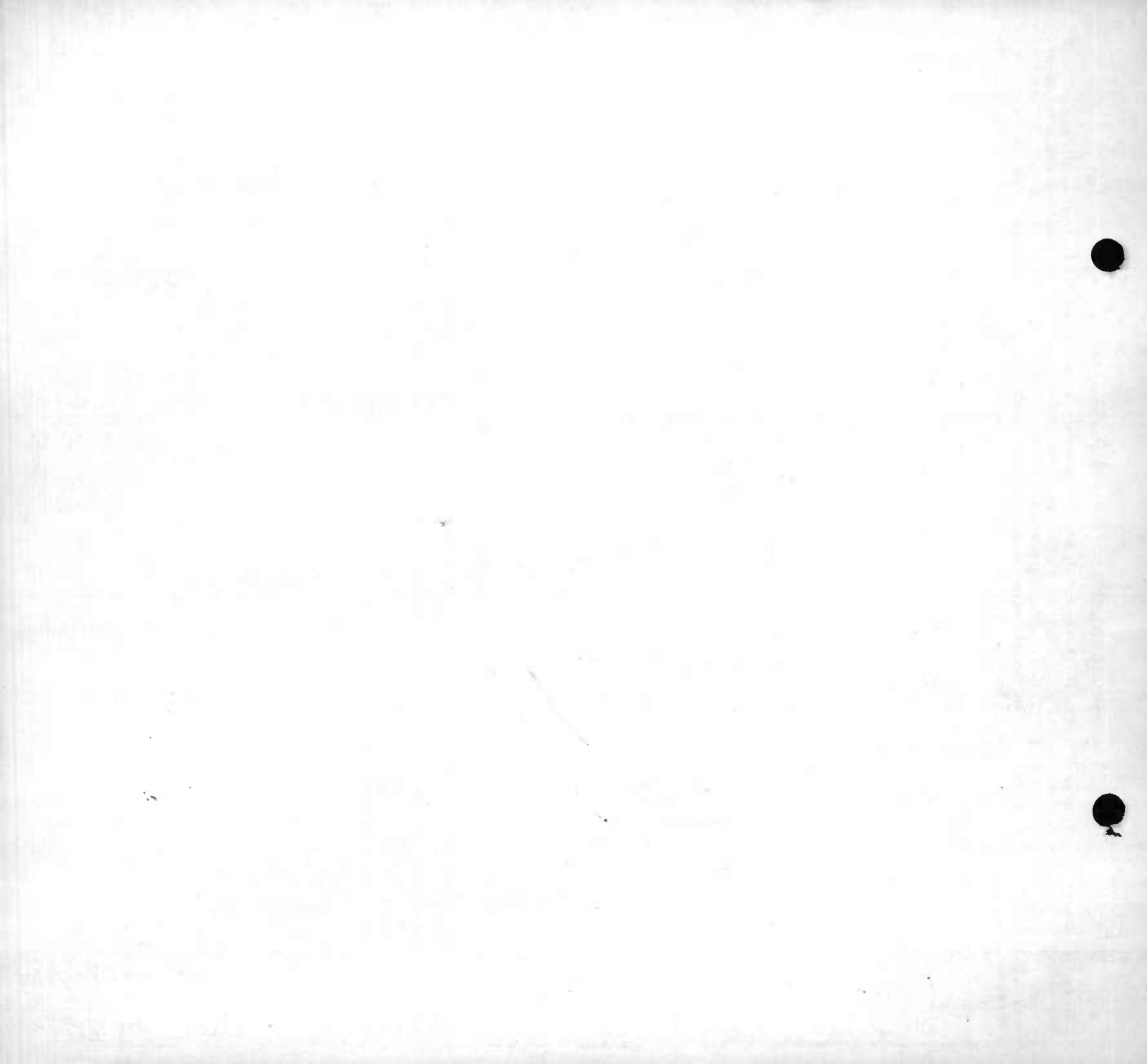
BIRTH NO. 65 6467				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6467	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) BREWER, ELIZABETH				2. DATE AND HOUR OF DEATH JUNE 20 - 1965 11 22 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 441 UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 12-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2603 MILES AVE.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/10/96	9. AGE (In years lost birthday) 68	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME DANIEL COOPER				14. MOTHER'S MAIDEN NAME KATHERINE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT WILLIAM E. BREWER JR ADDRESS 21210 319 ALPINE RD.			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH Recent thrombosis of the left ant. descending + circumflex coronary artery - acute myocardial infarction, left lateral wall. (A) DUE TO (B) DUE TO (C) DUE TO Severe coronary arteriosclerosis. congestive splenomegaly. cerebral arteriosclerosis. INTERVAL BETWEEN ONSET AND DEATH 2-3 days			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JUNE 19 19 65 to JUNE 20 19 65 , that (I) (we) last saw the deceased alive on JUNE 20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Chitsung Su				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED JUNE 20 1965	
23C. PHYSICIAN'S NAME (Type) Chi-Tsung Su				23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6-23-65	24C. NAME OF CEMETERY or CREMATORY MAY'S CHAPEL		24D. LOCATION (City, town, or county) (State) BALTO. COUNTY MD.			
25A. DATE REC'D BY HEALTH DEPT. JUN 22 1965		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR Paul E. Denoweth ADDRESS 321 3615			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 6514679 65 6468		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6468		4	
M.E. CASE NO.		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) STEPHEN LEE CALLOW		2. DATE AND HOUR OF DEATH 6/18/65		4 ¹⁰		A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GEN. HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 26-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3932 LYNDAL AVE					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 6/17/65	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME EUGENE CALLOW		14. MOTHER'S MAIDEN NAME PATRICIA PARKS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT EUGENE P. CALLOW		ADDRESS 3932 Lyndale Ave					
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Prenatal (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JUNE 17 19 65 to JUNE 18 19 65 , that (I) (we) last saw the deceased alive on JUNE 18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Roland J. J. J.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-18-65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/18/65		24C. NAME of CEMETERY or CREMATORY ST. STANISLAUS		24D. LOCATION (City, town, or county) (State) 6575 Boston rd BALTO, Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 22 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR George A. Weber		ADDRESS 705 S. ANN ST	

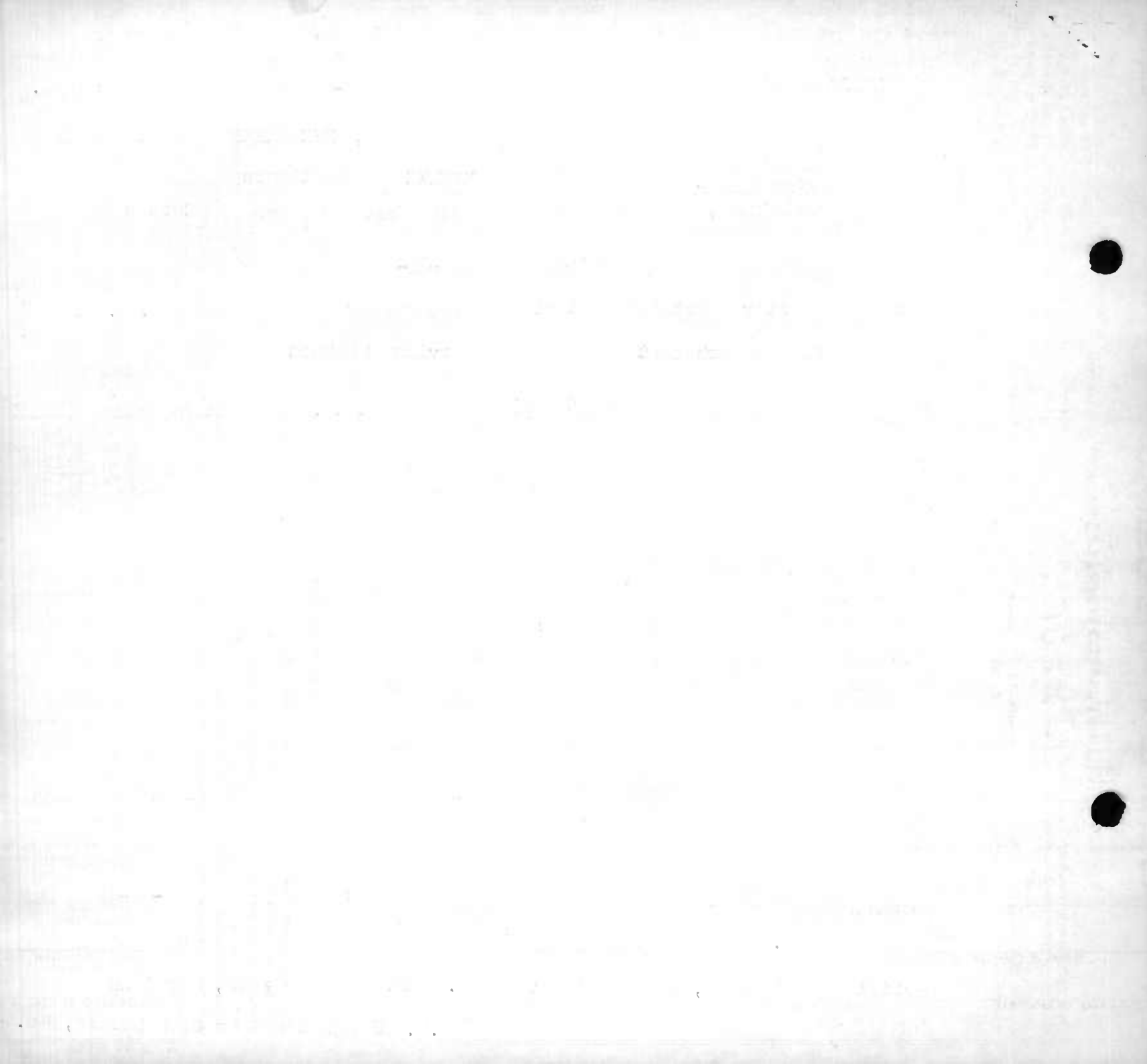


43-69-21 AM

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. 65 6469				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6469	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				(Jefferson) Jeff Arbogast		6-17-65 1:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Maryland, XXXXXX 25-05		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				D. STREET ADDRESS (If rural, give location)		4118 West Bay Court Curtis Bay	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
Male	White	Married	2-15-03	62			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Machine Operator			Bethlehem Steel		West Virginia		U. S. A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Elijah Arbogast				Arvisa Lambert			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				232 26 1133		RECORDS: B.C.H. 4940 Eastern Avenue #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)				(A) Carcinoma of Bladder with Metastasis 3 Years			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
None				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, loim, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 5-25 19 65 to 6-17- 19 65, that (I) (we) lost saw the deceased alive on 6-17- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Dr. Donald Baltzan						6-17-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Donald Baltzan				4940 Eastern Avenue #21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		June 21, 1965		Glen Haven Mem. Park		Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 22 1965		Robert E. Farley, M.D.		R.V. Singleton		Glen Burnie, Md.	



BIRTH NO. 65 6470		BALTIMORE CITY HEALTH DEPARTMENT		65 6470	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) MILDRED BAXLEY			2. DATE AND HOUR PRONOUNCED DEAD 6/17/65 5:45 p. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home and Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1832 E. Pratt St.		
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 3, 1927	9. AGE (In years last birthday) 38	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10B. KIND OF BUSINESS OR INDUSTRY Theatre	11. BIRTHPLACE (State or foreign country) Roberson Co. N. C.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Luther Parker			14. MOTHER'S MAIDEN NAME Hester Davis Parker		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS John Baxley 1832 E. Pratt St. Baltimore, Maryland		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of chest ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1832 E. Pratt St.	
21D. TIME OF INJURY (APPROX.) 6 17 65 3:30p.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? shot self in chest	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/18/65					
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6-20-1965	23C. NAME OF CEMETERY or CREMATORY Lumberton Cemetery		23D. LOCATION (City, town, or county) (State) Lumberton, Roberson Co. N. C.
24A. DATE REC'D BY HEALTH DEPT. JUN 22 1965		24B. NAME OF REGISTRAR R. E. Farley		24C. FUNERAL DIRECTOR ADDRESS Crumpler Funeral Home-Rae Ford, N. C. 131 Harris Ave.	

MAIL

MAIL

11/11/11

BIRTH NO.

65 6471

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 6471

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DAVID BIRTWELL HENNESSY

2. DATE AND HOUR PRONOUNCED DEAD

6-21-65

4:55 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Timonium

D. STREET ADDRESS (If rural, give location)

2438 Spring Lake Drive

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Aug. 20, 1920

9. AGE (In years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Grocery

11. BIRTHPLACE (State or foreign country)

Providence, Rhode Island

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

J. Hennessy

14. MOTHER'S MAIDEN NAME

Marion Birtwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

O-1 585 606

16. SOCIAL
SECURITY NO.

108 12 6225

17. INFORMANT

Rheta T. Hennessy (Wife)

ADDRESS

2438 Springlake Dr. Timonium, Md

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRI-
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Road

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

York Road - 26' South of

Windwood Drive intersection

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) 11:37
6 18 '65 P. m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Head-On Auto-Auto collision

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

6-21-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/21/65

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery Baltimore, Md.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 22 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Eugenia K. Seitz 5209 York Road
Seitz Funeral Home Balto. Md. 21212

ADDRESS

WALL-LEY POLING

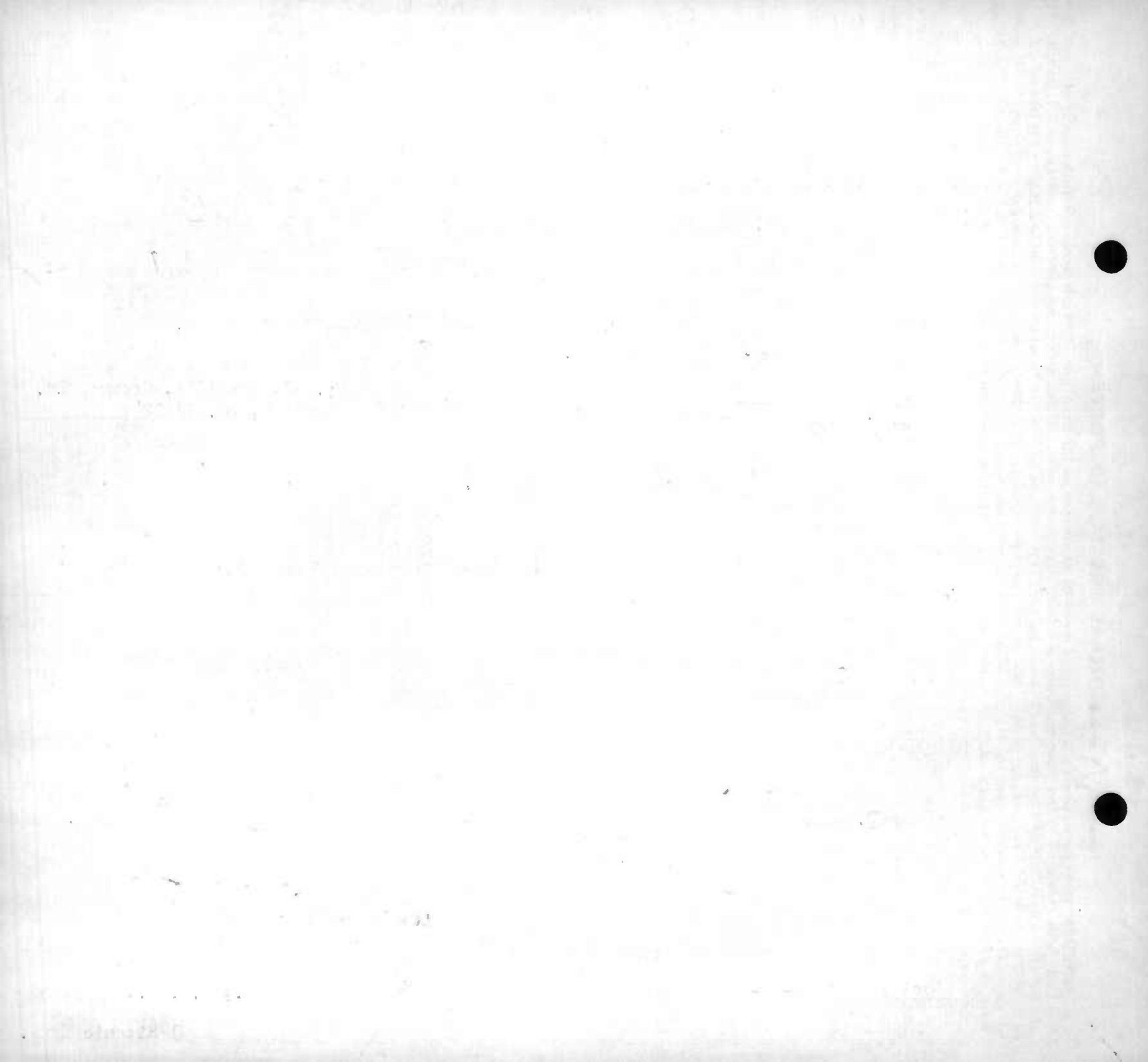
PAS CO. RENT

1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

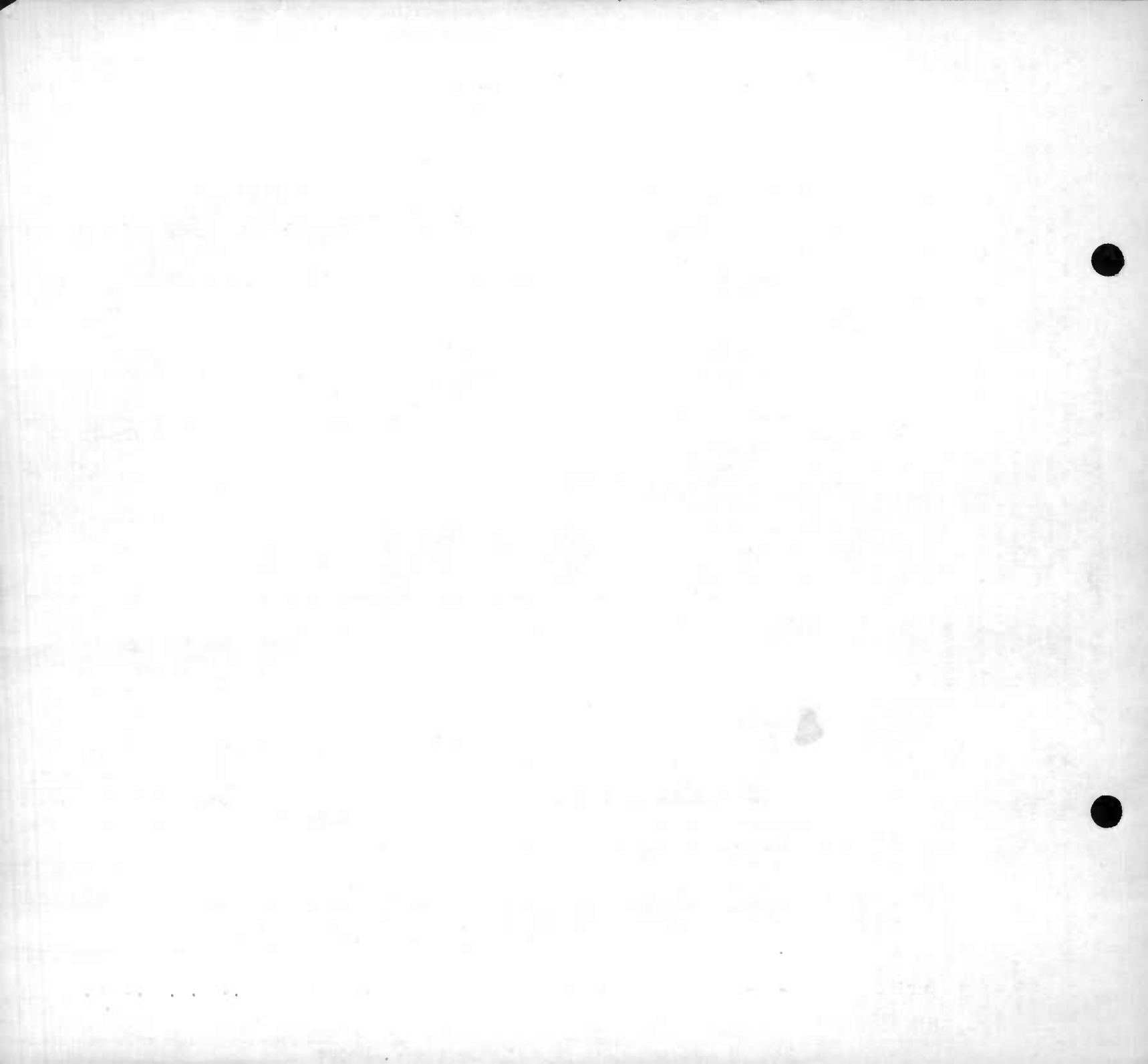
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6472	
BIRTH NO. 65 6472		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) RADZISZEWSKI, Mary Ann			2. DATE AND HOUR OF DEATH 6-19-65 1:50 P.M.		
3. PLACE OF DEATH KALDAMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pasadena		
			D. STREET ADDRESS (If rural, give location) Rt 11 Box 152A Bremen Rd.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never married	8. DATE OF BIRTH 5-1-65	9. AGE (In years last birthday) 0	If Under 1 Yr. Months: Days: Hours: Min. 1 18
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10B. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Joseph Radziszewski		
14. MOTHER'S MAIDEN NAME Sophia Mrozewski			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. none			17. INFORMANT mother		
18. 35-1X1			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
			(C) Diffuse brain damage -		
INTERVAL BETWEEN ONSET AND DEATH Life					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 6-9-1965 to 6-19-1965 , that (I) (we) last saw the deceased alive on 6-19-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE George J. Gance		23B. DATE SIGNED 6-19-65		23C. PHYSICIAN'S NAME (Type) University Hosp, Balto Md	
23D. ADDRESS M.D.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-21-1965	
24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Ritchie Hwy, A.A.Co., Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 22 1965	
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR George J. Gance		ADDRESS 4001 Ritchie Hwy.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

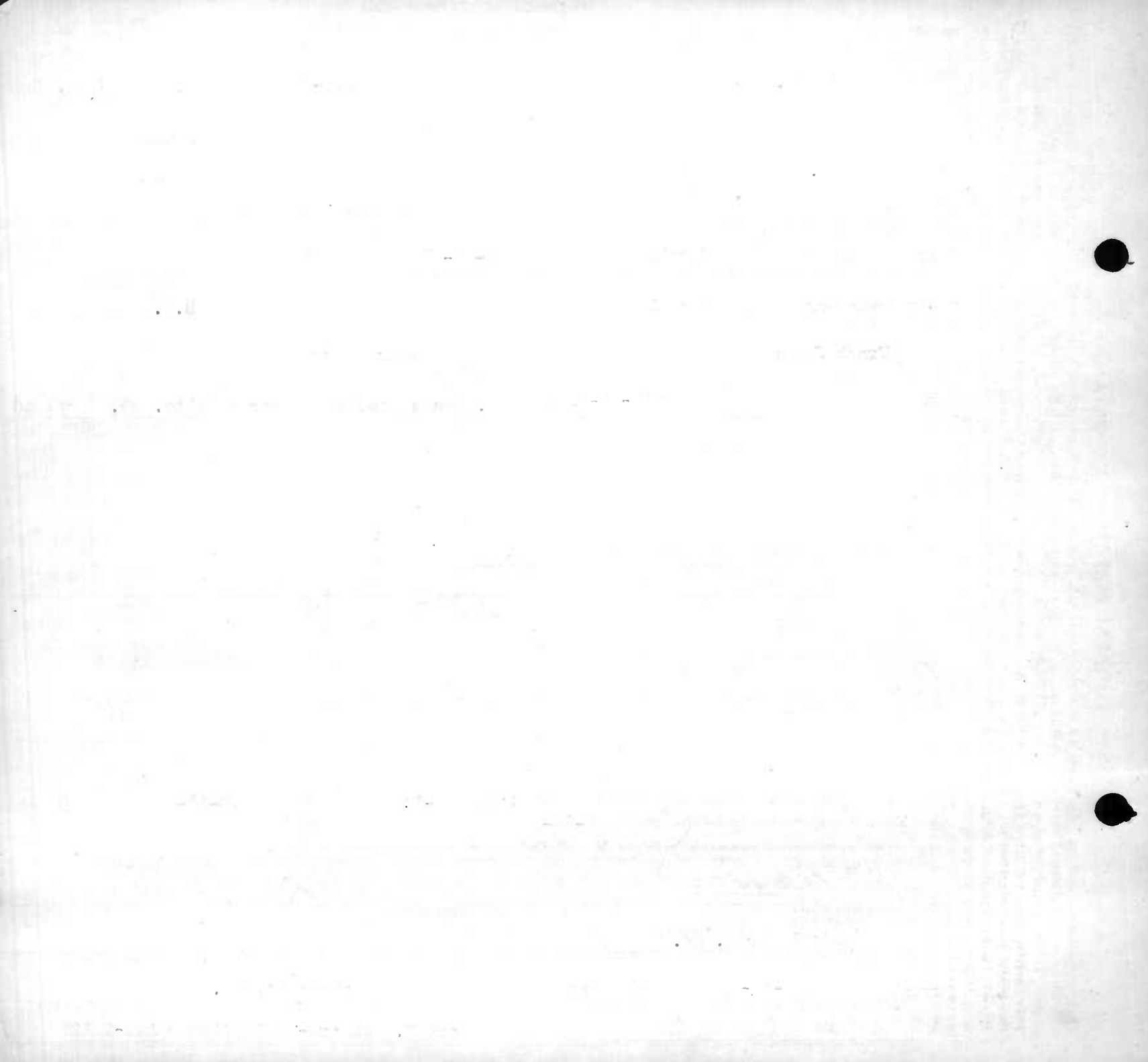
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6473	
BIRTH NO. 651386465 6473		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DALLA-MUTA, Donna Maria		2. DATE AND HOUR OF DEATH 6-18-65 10 45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 25-04		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		D. STREET ADDRESS (If rural, give location) 3608 BROOKLYN AVE.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) N. M.	8. DATE OF BIRTH 6-2-65	9. AGE (In years last birthday) 16	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) USA MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME RINO DALLA MUTA		14. MOTHER'S MAIDEN NAME Cleestina Pettenuzzo			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —	17. INFORMANT ADDRESS UNIVERSITY HOSPITAL		
18. 754.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Gastrointestinal Ulceration		CAUSE OF DEATH (A) CONGENITAL HEART DISEASE DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 16 days	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 14 19 65 to JUNE 18 19 65, that (I) (we) last saw the deceased alive on JUNE 18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alice B. Heisler MD		23B. DATE SIGNED June 18, 1965			
23C. PHYSICIAN'S NAME (Type) M.D.		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-21-1965		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery	
24D. LOCATION Ritchie Hwy., A.A.Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 22 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR ADDRESS George J. Gonca - 7001 N. Ritchie Hwy. George J. Gonca	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6474				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6474	
1. NAME OF DECEASED (Type or Print) Jones, Roland E				2. DATE AND HOUR OF DEATH 6-18-65 10:38 pm.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital Baltimore, Maryland 21229				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 5300 D. STREET ADDRESS (If rural, give location) 2213 Sulphur Spring Road			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-18-07	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) photo engraver		10B. KIND OF BUSINESS OR INDUSTRY Engraving		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frank Jones				14. MOTHER'S MAIDEN NAME Sarah Shaw			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-3591		17. INFORMANT ADDRESS St. Agnes Hospital Records Balto. 29, Maryland			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Coronary insufficiency				CAUSE OF DEATH (A) Acute Coronary insufficiency (B) Diabetes mellitus (C) A.S.C.V.D.		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 6-18-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that X (this hospital) attended the deceased from 10:15p 6-18-1965 to 6-18-1965 , that X (we) last saw the deceased alive on 6-18-1965 and that XXXX (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) (did not) view the body after death.							
23A. SIGNATURE Rafael Marin				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/18/65	
23C. PHYSICIAN'S NAME (Type) Rafael Marin, Md.				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-22-65		24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 22 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard-4107 Wilkens Ave-21229			



BIRTH NO.

65 6475

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 6475

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN E. SCHROEDER

2. DATE AND HOUR PRONOUNCED DEAD

6/18/65 9:25 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2038 Grinnalds Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

6-3-98

9. AGE (in years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Calvert Distillery

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Ernest E. Schroeder

14. MOTHER'S MAIDEN NAME

Belle Kelly

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

212-05-2233

17. INFORMANT ADDRESS

Morrell Pk, Md. 21230
Mrs. Catherine S. Schroeder-2038 Grinnalds Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenio, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

6/18/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-22-65

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith

23D. LOCATION

(City, town, or county) (State)

21206
Trumps Mill Rd., Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 22 1965

Howard H. Hubbard-4107 Wilkens Ave-21229

U.S. DEPARTMENT OF JUSTICE

1962

IN RE: [illegible]

Case No. [illegible]

RETURN OF RECEIPT

FILE NO. [illegible]

DATE OF RECEIPT [illegible]

BY [illegible]

RECEIVED BY [illegible]

[Handwritten signature]

BIRTH NO. 65 6476 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 6476

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BERNARD J. ZAMENSKI, JR.

2. DATE AND HOUR PRONOUNCED DEAD

6/18/65 10:45 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Dundalk

D. STREET ADDRESS (If rural, give location)

7133 Railway Ave.

21222

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

July 25- 1946

9. AGE (In years
last birthday)

18

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truck Assembly work

Chevrolet Div. General Motors Corp.

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Bernard J. Zamenski Sr.

14. MOTHER'S MAIDEN NAME

Christine Mileto

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL
SECURITY NO.

212-46-1738

17. INFORMANT

ADDRESS

Mr. & Mrs. B. J. Zamenski, Sr. # 4,a,b,c,d.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Compression of chest and fracture of spine
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

German Hill Rd. and Delbert Ave.

21D TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6 18 65 9:45 p.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

driver of auto

which struck pole

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

6/19/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

June 22-1965

23C. NAME OF CEMETERY or CREMATORY

Sacred Heart of Jesus

23D. LOCATION

(City, town, or county)

German Hill Rd. Bal. Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 22 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

John J. Duda 7922 Wise Ave. Dundalk, Md. 22

ADDRESS

VALLEY FORGE

Handwritten signature

FUNERAL DIRECTOR: IMPORTANT

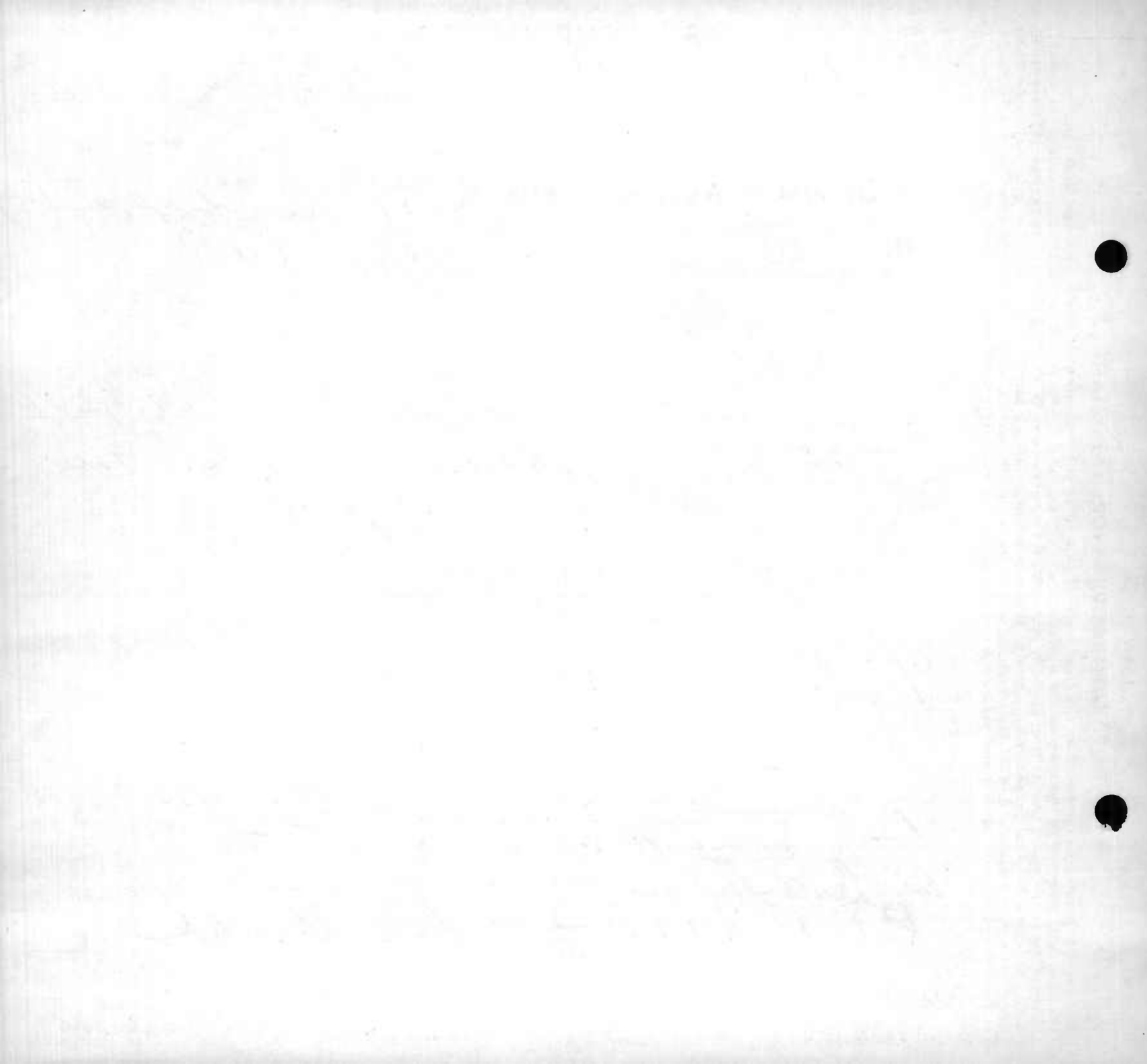
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6477				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6477	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) EDWIN WEBSTER DAVIS				2. DATE AND HOUR OF DEATH 6/18/65 1124 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 4-02 D. STREET ADDRESS (If rural, give location) 102 W. BACA			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WID.	8. DATE OF BIRTH 3/20/89	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE HENRY DAVIS				14. MOTHER'S MAIDEN NAME ADELIN M. LILLY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Vicki Bwan ADDRESS 608 D Union Ave, Md. 21078	
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Septicemia				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 8 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO Abscess of R Flank		2 weeks.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma of R Colon				(C) DUE TO		6 1/2 mths	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/8 19 65 to 6/18 19 65 , that (I) (we) last saw the deceased alive on 6/18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Edward A. Perera				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/18/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/21/65		24C. NAME of CEMETERY or CREMATORY Waverly		24D. LOCATION (City, town, or county) (State) Delta, Pa.	
25A. DATE REC'D BY HEALTH DEPT. JUN 22 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Thurman P. Hand		ADDRESS Hand, Mar	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

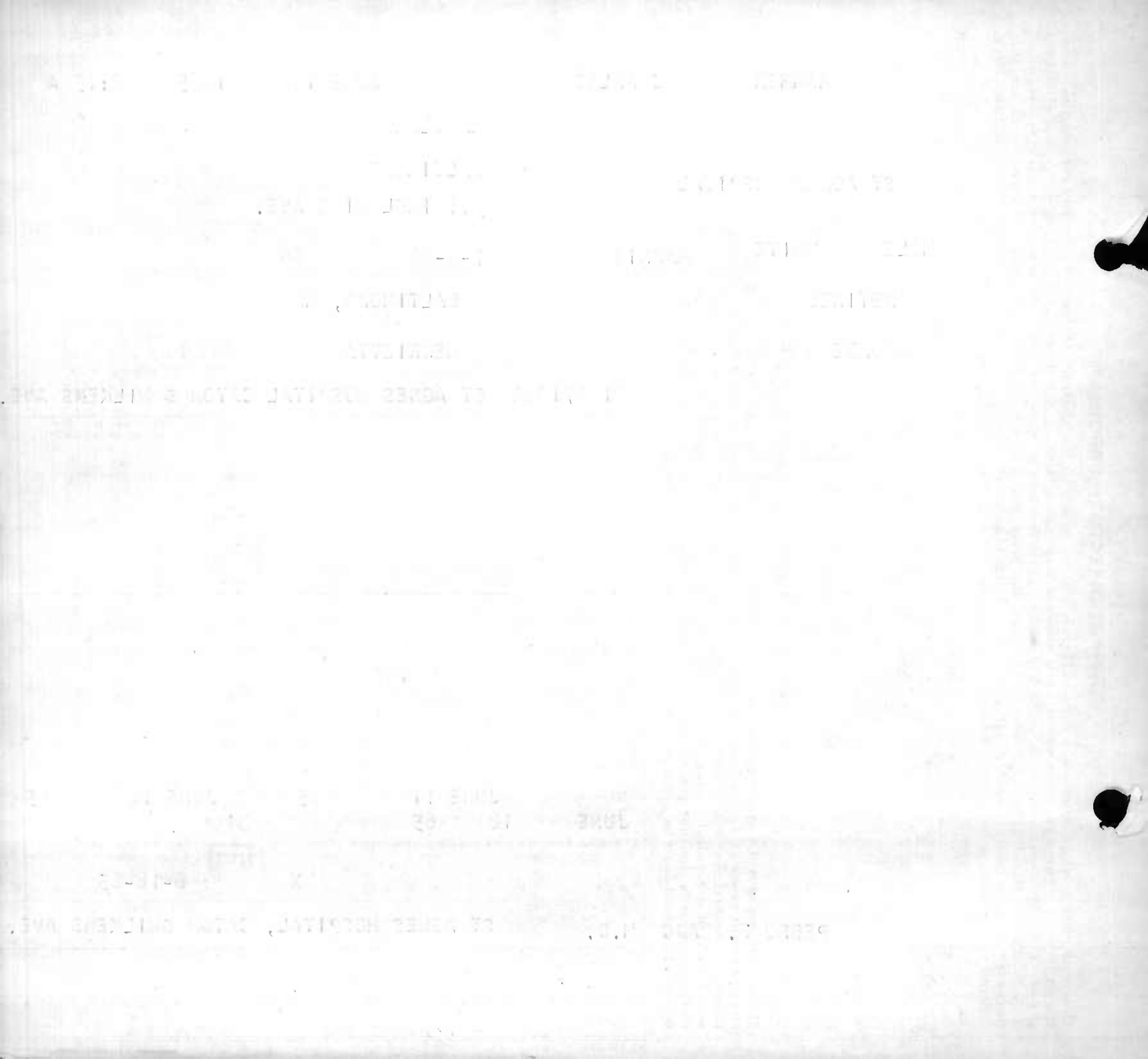
BIRTH NO. 65 6478				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6478	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Herman Fuld</u>				2. DATE AND HOUR OF DEATH <u>6-20-65</u> <u>9:5</u> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <u>MD</u>		B. COUNTY <u>27-18</u>	
<u>Sinai Hosp of Balto</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		<u>Balto</u>	
				D. STREET ADDRESS (If rural, give location)		<u>4021 Lewiston Ave #15</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>1/18/01</u>	9. AGE (In years last birthday) <u>64</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		<u>clerk</u>		<u>Germany</u>		<u>U. S. A.</u>	
13. FATHER'S NAME <u>Lazarus Fuld</u>				14. MOTHER'S MAIDEN NAME <u>Eva Selig</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-033763</u>		17. INFORMANT <u>Jacob Fuld</u>		ADDRESS <u>4101 Crest Hgts Rd</u>	
18. <u>154X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) <u>Adenocarcinoma of the Rectosigmoid</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>7 mos</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>6/64</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Adenocarcinoma of the Rectosigmoid</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>4/7</u> <u>1965</u> to <u>6/20</u> <u>1965</u> , that (1) (we) last saw the deceased alive on <u>6/20</u> <u>1965</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Richard Gerald Shugarman,</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>6/20/65</u>			
23C. PHYSICIAN'S NAME (Type) <u>Richard Gerald Shugarman,</u> M.D.				23D. ADDRESS <u>Sinai Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-22-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cherry Avenue Chesel Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Rosedale Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 22 1965</u>		25B. NAME OF REGISTRAR <u>R. G. E. Fuld</u>		25C. FUNERAL DIRECTOR <u>Jack Lewis</u>		ADDRESS <u>Bro 2100 Euter Rd</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6479		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6479	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
KAMMER CHARLES		JUNE 18 1965		9:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
ST AGNES HOSPITAL		MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
		BALTIMORE		53-00	
		D. STREET ADDRESS (If rural, give location)			
		511 INGLESIDE AVE.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months: Days: Hours: Min.
MALE	WHITE	MARRIED	7-8-84	80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED		INSURANCE		BALTIMORE, MD	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
GEORGE KAMMER		HENRIETTA - (UNKNOWN)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		212071924		ST AGNES HOSPITAL CATON & WILKENS AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		JUNE 11 19 65		to JUNE 18 19 65.	
that (I) (we) last saw the deceased alive on		JUNE 18 19 65		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Pedro F. Bajo				6-18-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
PEDRO F. BAJO M.D.		ST AGNES HOSPITAL, CATON & WILKENS AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		6-21-65		Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Baltimore Maryland		JUN 22 1965		Robert E. Farley M.D.	
24G. FUNERAL DIRECTOR ADDRESS		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR	
Edw. Marshall Jr - Catonsville - Md					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 65 6480										
REGISTERED NO. 65 6480										
CERTIFICATE OF DEATH										
1. NAME OF DECEASED (Type or Print) RADOVICH, GERALD LAWRENCE					2. DATE AND HOUR OF DEATH 6/19/65 12:10 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 15-13 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2527 BOARMAN AVE					
5. SEX M	6. RACE CAU	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 9/30/29	9. AGE (In years last birthday) 35	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK			10B. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) PA. (Philadelphia, Pa)		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME CHARLES Radovich					14. MOTHER'S MAIDEN NAME MARTHA HILLMAN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES KOREA			16. SOCIAL SECURITY NO. 156-16-2488		17. INFORMANT ADDRESS PT & WIFE 2527 Boarman Ave.					
18. 190.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) AMELANOTIC MELANOMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. WIDESPREAD METASTASES					CAUSE OF DEATH (A) AMELANOTIC MELANOMA DUE TO WIDESPREAD METASTASES (B) METASTASES DUE TO (C)					
19. DATE OF OPERATION 0					20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5/28/65 19 to 6/19/65 19, that (I) (we) last saw the deceased alive on 6/19/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE Charles A. Asplen					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/19/65			
23C. PHYSICIAN'S NAME (Type) CHARLES H ASPLEN					23D. ADDRESS UNIVERSITY HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/23/65		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 22 1965			25B. NAME OF REGISTRAR Robert E. Farley			25C. FUNERAL DIRECTOR Ed. Vernon Gorman			ADDRESS 4611 Park Heights Ave.	

(S. 111) (S. 111) (S. 111)

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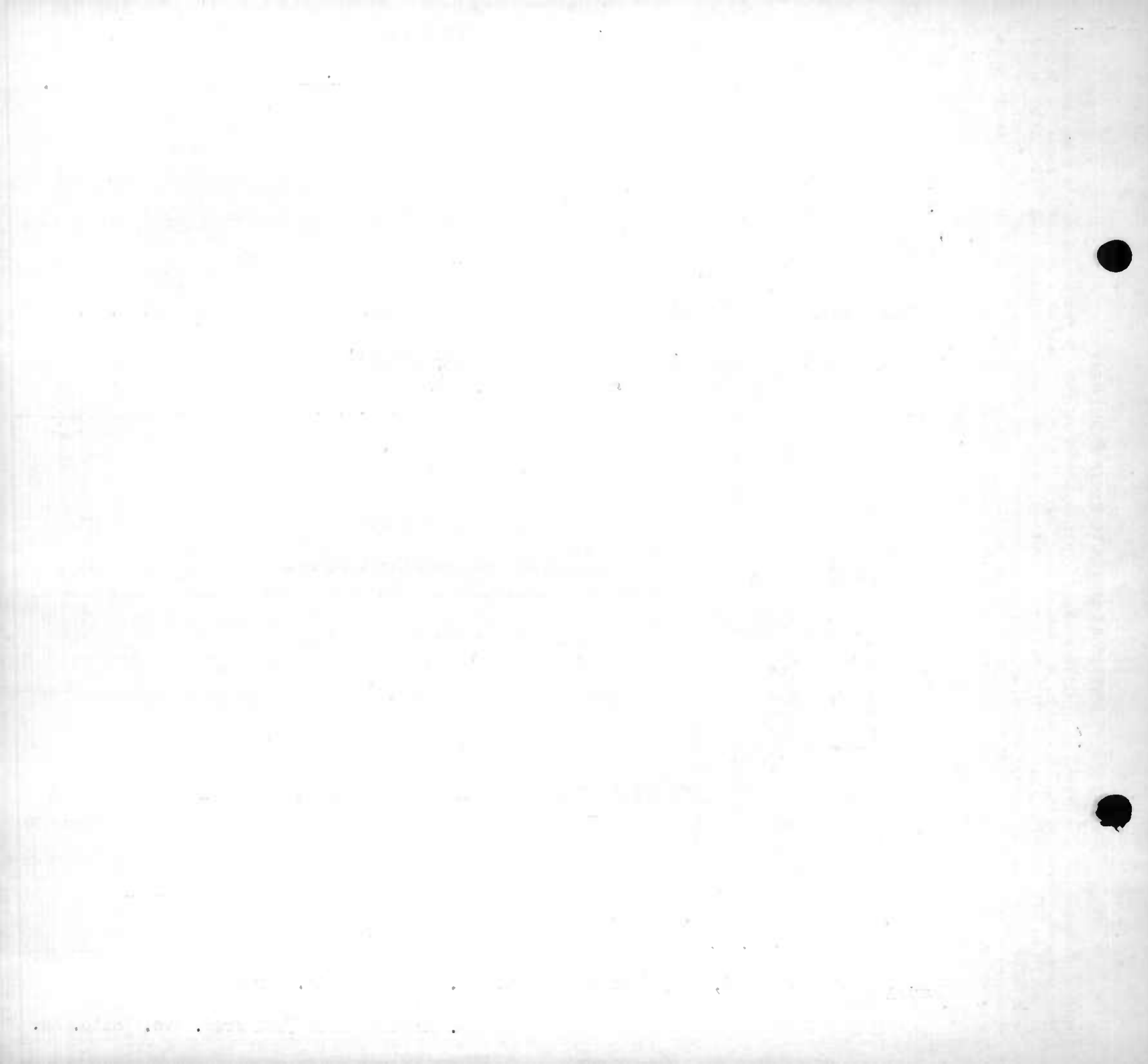
(S. 111) (S. 111) (S. 111)

(S. 111) (S. 111) (S. 111)

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 6481		BALTIMORE CITY HEALTH DEPARTMENT		65 6481	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No. _____	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Joseph Dunne			6-19-65 8:30 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224			A. STATE Maryland		
			B. COUNTY Baltimore		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
Baltimore			221 South Loudon Avenue #21229		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	White	Married	9-8-1881	83	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Office Worker		Railroad		Massachusetts	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Luke Dunne			Nora Keenan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No					RECORDS: B.C.H. 4940 Eastern Avenue #21224
18. 331 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) Septicemia DUE TO		INTERVAL BETWEEN ONSET AND DEATH
			(B) Decubiti, Infected DUE TO		6 Weeks
			(C) Cerebro Vascular Accident		4 Months
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Arteriosclerosis, Generalized		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-18 19 65 to 6-19 19 65 , that (I) (we) last saw the deceased alive on 6-19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. B. Zachary				23B. DATE SIGNED 6-19-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. J. B. Zachary				4940 Eastern Avenue #21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		June 22, 1965		New Cathedral Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 22 1965		Robert E. Farley, M.D.		G. Truman Schwab 3512 Fred. Ave. Balto. Md.	



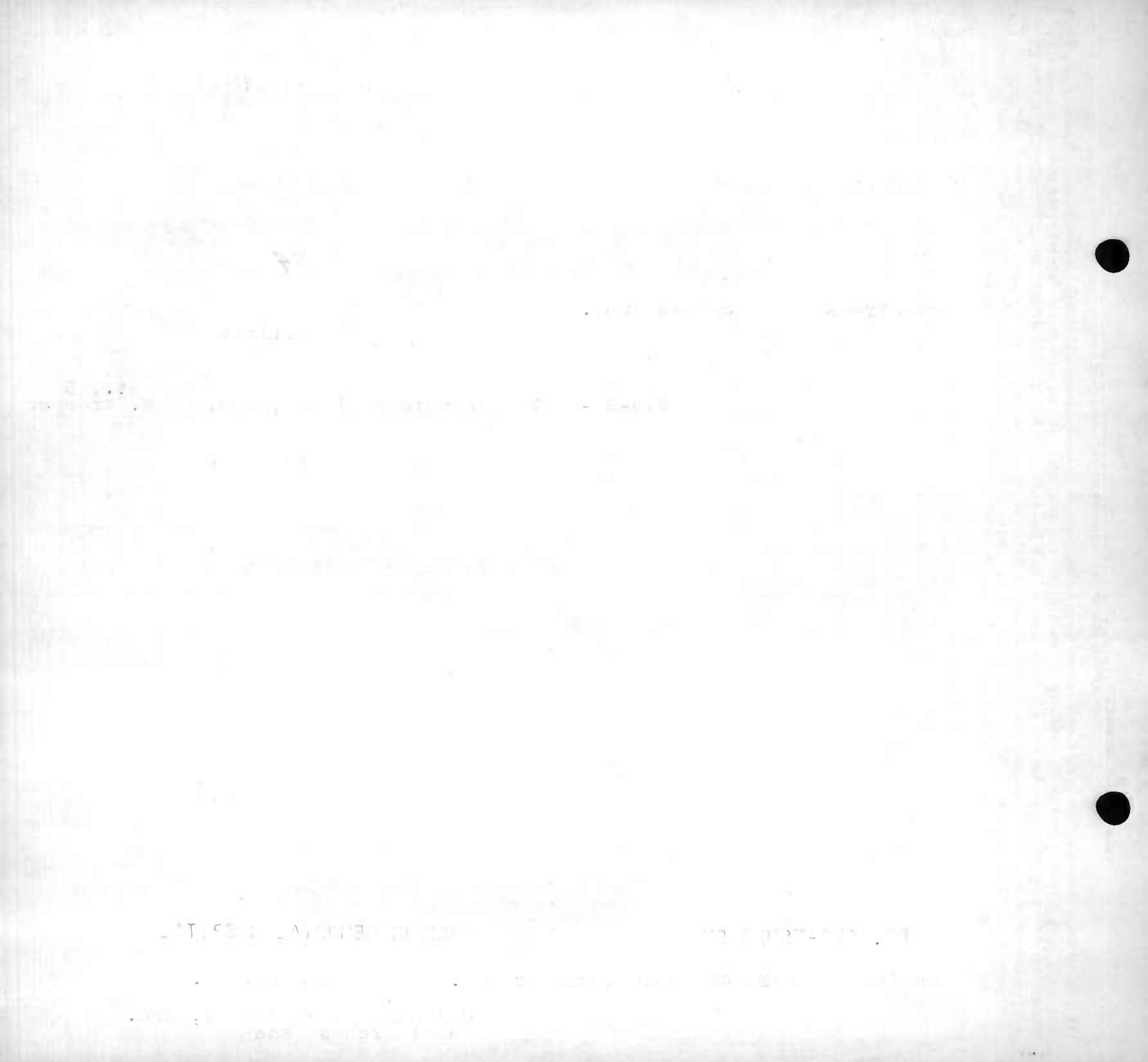
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6482	
BIRTH NO. 65 6482		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WALTER MILTON NAMUTH, SR.		2. DATE AND HOUR OF DEATH June 18, 1965 10 p.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2709 Ashland Ave., Baltimore, Md., 21205		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 7-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2709 Ashland Ave.,			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 2/20/1884	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Phone Installer		10B. KIND OF BUSINESS OR INDUSTRY C & P Tel. Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-05-0481		17. INFORMANT Lorraine Walker Namuth, wife, above	
18. 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) DUE TO Coronary Thrombosis (B) DUE TO Cerebral artery disease (C) Gastric Ulcer		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 year 10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Secondary Anemia		1 year			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 5 1965 to June 18 1965 , that (I) (was) last saw the deceased alive on June 18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE Louis F. Kleines M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) LOUIS F. KLEINES M.D.		23D. ADDRESS 2623 E. Monument St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/22/65		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 22 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.	
				ADDRESS 2601 E. Madison St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

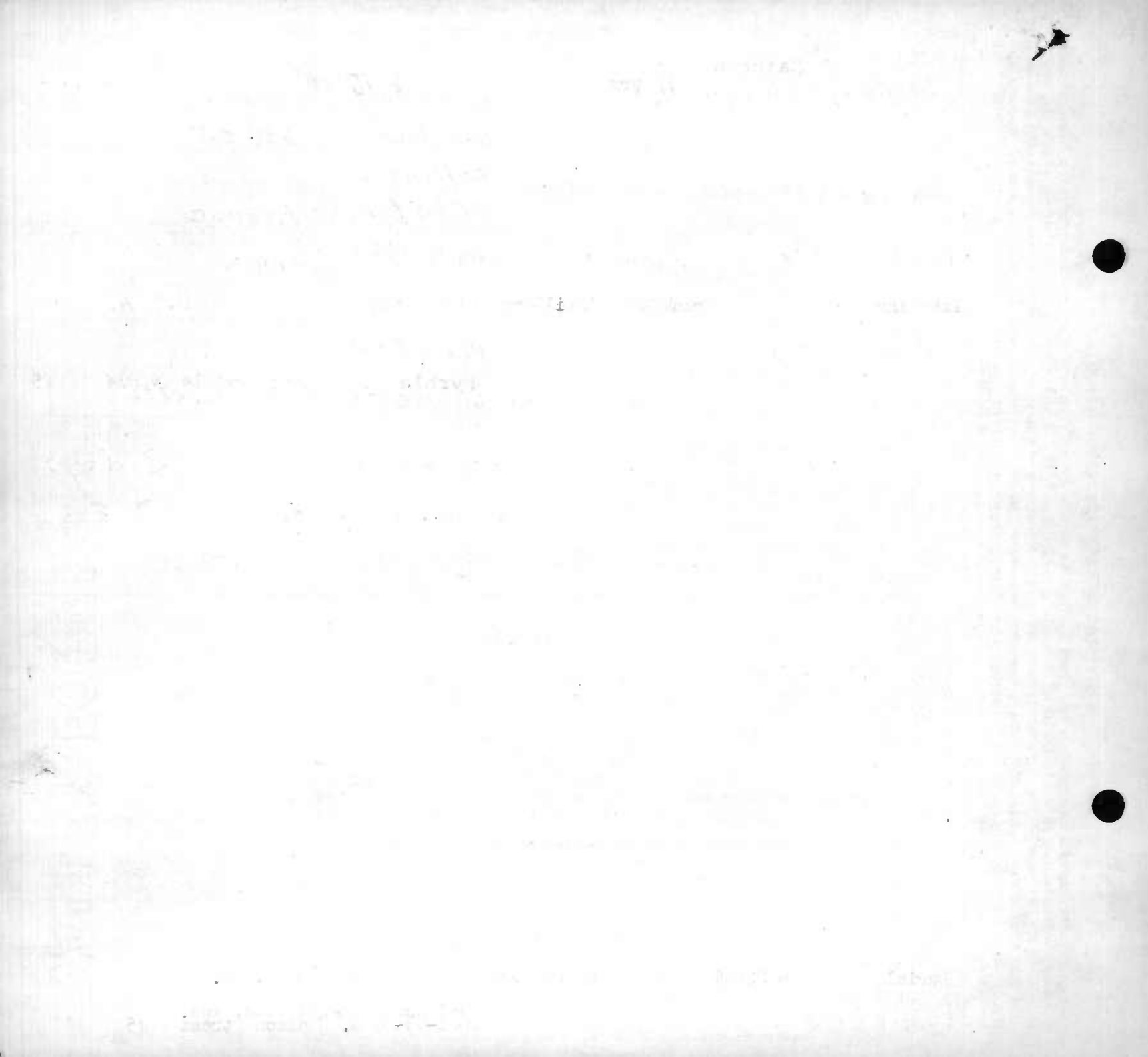
BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 65 6483					
BIRTH NO. 65 6483					M.E. CASE NO. 65 6483					
1. NAME OF DECEASED (Type or Print) CIMINO, SANTA					2. DATE AND HOUR OF DEATH JUNE 18 - 1965 2 10 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL					A. STATE MARYLAND					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
					D. STREET ADDRESS (If rural, give location) 733 E. 36TH ST					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 8-26-1890	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress			10B. KIND OF BUSINESS OR INDUSTRY Schloss Bros.		11. BIRTHPLACE (State or foreign country) ITALY			12. CITIZEN OF WHAT COUNTRY? AMERICAN		
13. FATHER'S NAME JOSEPH D'ANNA					14. MOTHER'S MAIDEN NAME Fertitta THERESA FERTETTA					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 216-24-0757		17. INFORMANT Salvatore Cimino, son,			ADDRESS St., 5 602 N. Streeper		
18. 154X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH MO - 42					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) CARCINOMA of Rectum with METASTASIS					
					(B) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(C) BRONCHOPNEUMONIA FS					
					(D) DUE TO					
19A. DATE OF OPERATION 2					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from JUNE 17 1965 to JUNE 18 1965 , that (I) (we) last saw the deceased alive on JUNE 18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Chi Tsung Su								23B. DATE SIGNED JUNE 18 65		
23C. PHYSICIAN'S NAME (Type) DR. CHI-TSUNG SU					23D. ADDRESS UNION MEMORIAL HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/22/65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.			24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 22 1965			25B. NAME OF REGISTRAR Robert E. Farley			25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane			ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

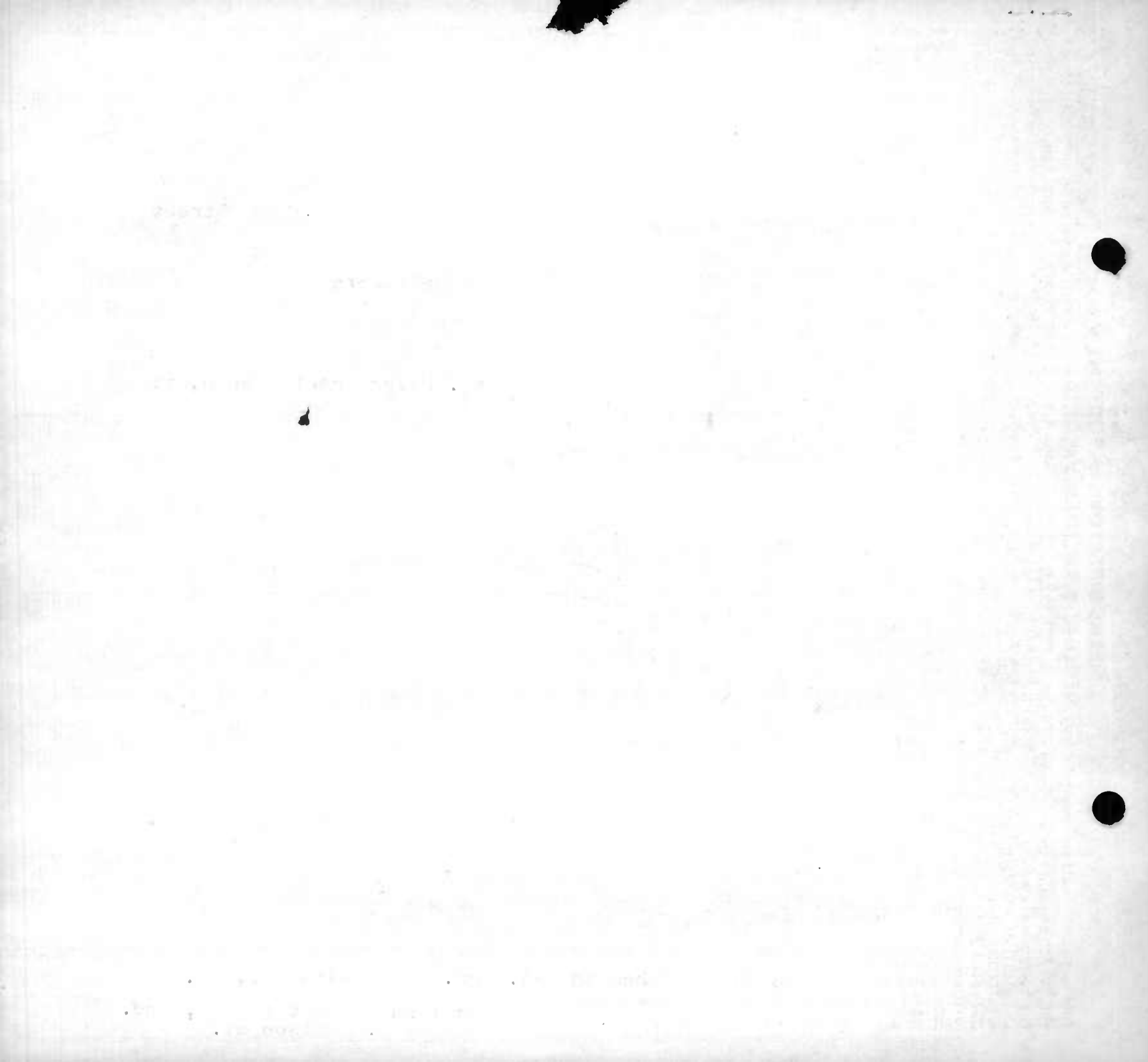
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6484		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6484	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Kathryn Mary Kendall, Cathryn Mary		2. DATE AND HOUR OF DEATH 6-10-65 12:30 A.M.	
3. PLACE OF DEATH (If not in hospital or institution, give street address or location) no. Charles St. Gen. Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 20205 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5085 Orville Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH July 7, 1883	9. AGE (In years last birthday) 81 yrs.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labeling one		10B. KIND OF BUSINESS OR INDUSTRY Frankfort Distillery		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Myers			14. MOTHER'S MAIDEN NAME Mary Sommers		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-03-9140	17. INFORMANT Myrtle Evans - daughter		ADDRESS 5085 Orville Avenue #5
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) SEPTICEMIA post op.		CAUSE OF DEATH (A) DUE TO GANGRENE left foot (B) DUE TO DIABETES MELLITUS UNCONTROLLED (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 days 17 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. GENERALIZED ARTERIOSCLEROSIS			
19A. DATE OF OPERATION 36.15.1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE left foot		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 6.15.1965		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6.15.1965 to 6.19.1965 and that (I) (we) lost saw the deceased alive on 6.18.1965 and that in (my) (our) opinion death occurred on the date 6.19.1965 and how and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harold H. Fauter				23B. DATE SIGNED 6.19.65	
23C. PHYSICIAN'S NAME (Type) HAROLD H. FAUTER		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/22/65		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 22 1965			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc		ADDRESS 2601-03-05 E. Madison Street #5	



Released on approval of Medical Examiner
FURNAL DIRECTOR: IMPORTANT: Approved & Authorized
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6485		ORE CITY HEALTH DEPARTMENT		Registered No. 65 6485	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN S VANKO		2. DATE AND HOUR OF DEATH 6-18-65 9:30pm	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 7-02		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DON SECOURS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 5		D. STREET ADDRESS (If rural, give location) 725 N GLOVER Street	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12-27-01	9. AGE (In years last birthday) 63	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER FOR CITY		10B. KIND OF BUSINESS OR INDUSTRY MAINTENANCE IN		11. BIRTHPLACE (State or foreign country) Baltimore MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN VANKO		14. MOTHER'S MAIDEN NAME MARY MARSHALL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES NAVY 1918		16. SOCIAL SECURITY NO. 212-8-0214		17. INFORMANT Mrs. Helen Shanta Vanko, wife, ADDRESS 725 N GLOVER SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) E903.0 Fractured Hip.		CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH 12 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Liver cirrosis					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) X		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
21C. WHERE DID INJURY OCCUR? feel at home - moving from bed to chair 7-02		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPRX.) 6 6 65		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from June 9 1965 to June 18 1965, that (I) (we) last saw the deceased alive on June 18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Francesco Mangione		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-18-1965	
23C. PHYSICIAN'S NAME (Type) FRANCESCO MANGIONE		M.D.		23D. ADDRESS DON SECOURS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/22/65		24C. NAME of CEMETERY or CREMATORY Bohemian Nat. Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 22 1965		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601 E. Madison St.		25D. ADDRESS 2601 E. Madison St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 6486		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6486	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY ANNE MCCUSKER		2. DATE AND HOUR OF DEATH 6-18-65		6:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MD.		B. COUNTY ALLEGHENY	
503 SO. ANN ST.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) LITTLE ORLEANS, MD.			
				D. STREET ADDRESS (If rural, give location) 57-00			
5. SEX FE	6. RACE WH	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH JUNE 25, 1881	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD ASH KETTLE				14. MOTHER'S MAIDEN NAME ELIZABETH CLAY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT (Son) CHARLES MCCUSKER		ADDRESS 503 So. ANN	
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-15 196 5 to 6-18 196 5 . that (I) (we) last saw the deceased alive on 6-18 196 5 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sebastian Russo				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-18-65	
23C. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO		23D. ADDRESS 5017 HARFORD Rd.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6.22.65		24C. NAME OF CEMETERY or CREMATORY ST. PETERS CATHOLIC		24D. LOCATION (City, town, or county) (State) HANCOCK WASHINGTON MD.	
25A. DATE REC'D BY HEALTH DEPT. JUN 22 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Howard J. Stone Hancock Md.			

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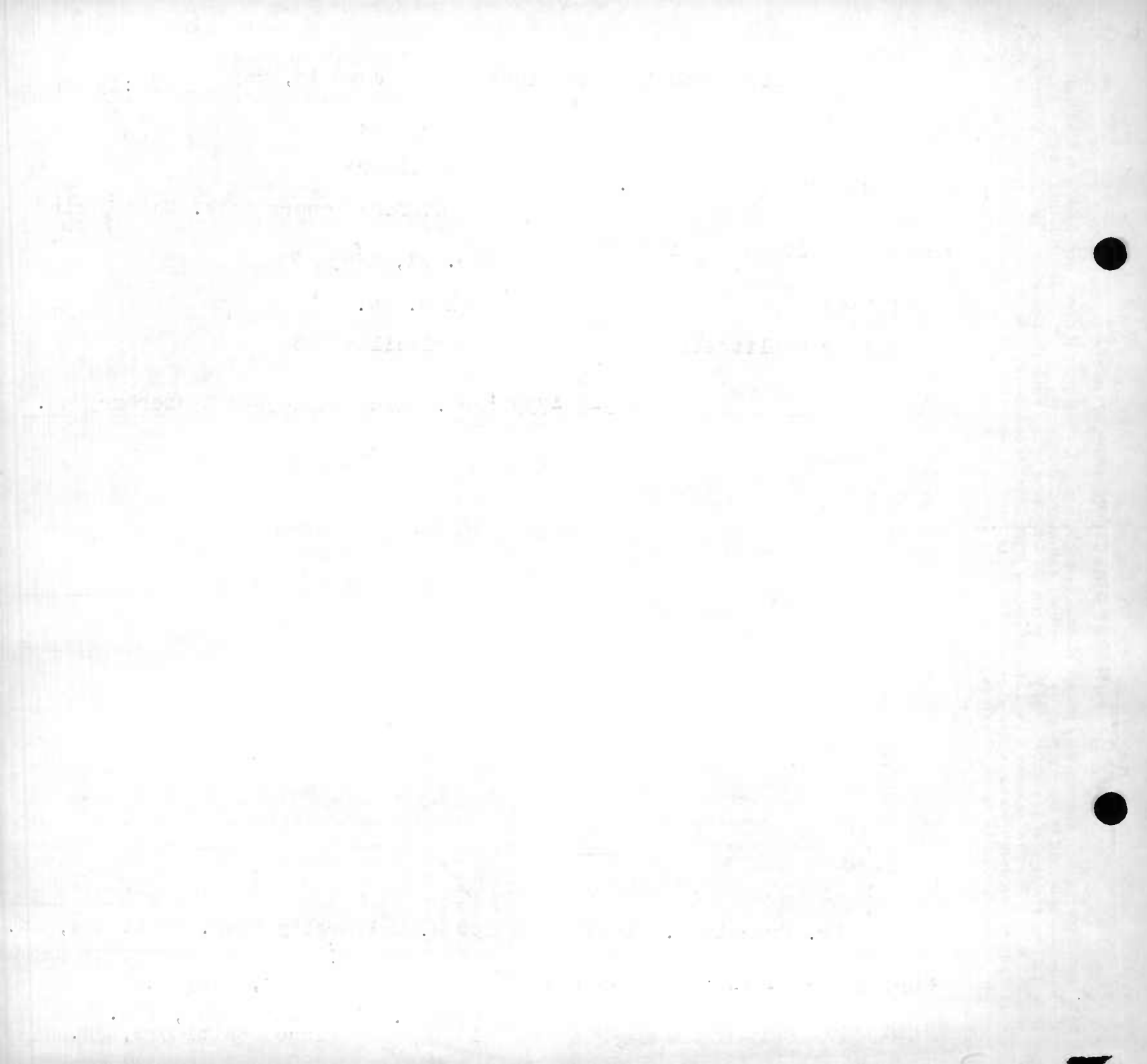
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6487		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6487	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Eliza Woodside Linthicum		June 18, 1965 12:15 am M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Guilford Towers Apts.			Maryland		
5. SEX			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
Female			Baltimore		
6. RACE			D. STREET ADDRESS (If rural, give location)		
White			Guilford Towers Apts. Cold Spring Lane		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH		9. AGE (In years lost birthday)
Widowed			Feb. 21, 1895		70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Companion			Balto. Md.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Oliver Hoblitzell			Priscilla Paca		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			219-30-7392		Mrs. Miles White 3943 Canterbury Rd.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
410 X I			Rheumatic Heart Disease		? yrs.
ANTECEDENT CAUSES			(A) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Metabolic insufficiency + Metabolic Stenosis		
(B) DUE TO			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<input type="checkbox"/>					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 2/15/43 19 to 6/18/65 19, that (I) (we) last saw the deceased alive on 6/17/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE/SIGNED	
Francis W. Gluck				6/19/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Francis W. Gluck				100 W. University Pkwy. Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-21-65		Lorraine	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 22 1965		Robert E. Farber		John O. Mitchell & Sons, Inc. 1900 Eutaw Place Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6488	
BIRTH NO. 65 6488		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MRS. CHARLOTTE H. KEEN		2. DATE AND HOUR OF DEATH JUNE 19, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 6303 MOSSWAY		A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 6303 MOSSWAY			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 7/16/80	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME GEORGE HEBNER		14. MOTHER'S MAIDEN NAME MINNIE PFITSCH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. WM SCHMITZ CHARLESTON HALL APTS	
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ARTERIOSCLEROTIC HEART Ds (B) Generalized Arteriosclerosis (C)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs 1 indef.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 19 62 to 19 JUNE 1965 , that (I) (we) last saw the deceased alive on 19 JUNE 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 21 June 65	
23C. PHYSICIAN'S NAME (Type) John B. DeHoff		23D. ADDRESS 1701 Meridene Drive Balto. 12, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/22/65		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK	
24D. LOCATION BALTIMORE, Md.		24E. DATE REC'D BY HEALTH DEPT. JUN 22 1965			
25A. NAME OF REGISTRAR Robert E. Farley		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR H.W. MEARS & SON 805 N. CALVERT ST	

Generalship Administration 1947
* American Economic Warfare 1947

12 June 47
19 June 47

James M. Smith
100 -

21 June 47

H-5321

65 6489

BALTIMORE CITY HEALTH DEPARTMENT

65 6489

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)**Sophia or SOPHIE HANDZLIK**

2. DATE AND HOUR PRONOUNCED DEAD

6-20-65**9:55 P.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Essex

D. STREET ADDRESS (If rural, give location)

802 Woodrow Avenue

5. SEX

Female

6. RACE

White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)**Married**

8. DATE OF BIRTH

April 18, 18899. AGE (In years
last birthday)**76**If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)**Housewife**

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Poland12. CITIZEN OF
WHAT COUNTRY?**U.S.A.**

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)**No**16. SOCIAL
SECURITY NO.**212-07-1041B Frank Handzlik 802 Woodrow Ave. Essex**

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) **Arteriosclerotic cardiovascular disease**
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)**PETER W. RIECKERT, M.D.**

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

6-21-6523A. BURIAL CREMATION,
REMOVAL (Specify)**Burial**

23B. DATE

June 24, 65 Holy Cross Cemetery

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

German Hill Rd. Baltimore

24A. DATE REC'D BY HEALTH DEPT.

JUN 22 1965

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

ADDRESS

The Dippel Brothers Inc. 1800 E. Lombard**21231**

German War II, Baltimore

June 24, 65 Holy Cross Cemetery

Burial

W. A. Bell

512-07-10118 Frank Randall 502 Woodrow Ave. Essex

unknown

unknown

At Home

Indigent

Poland

U.S.A.

Married

March 18, 1884

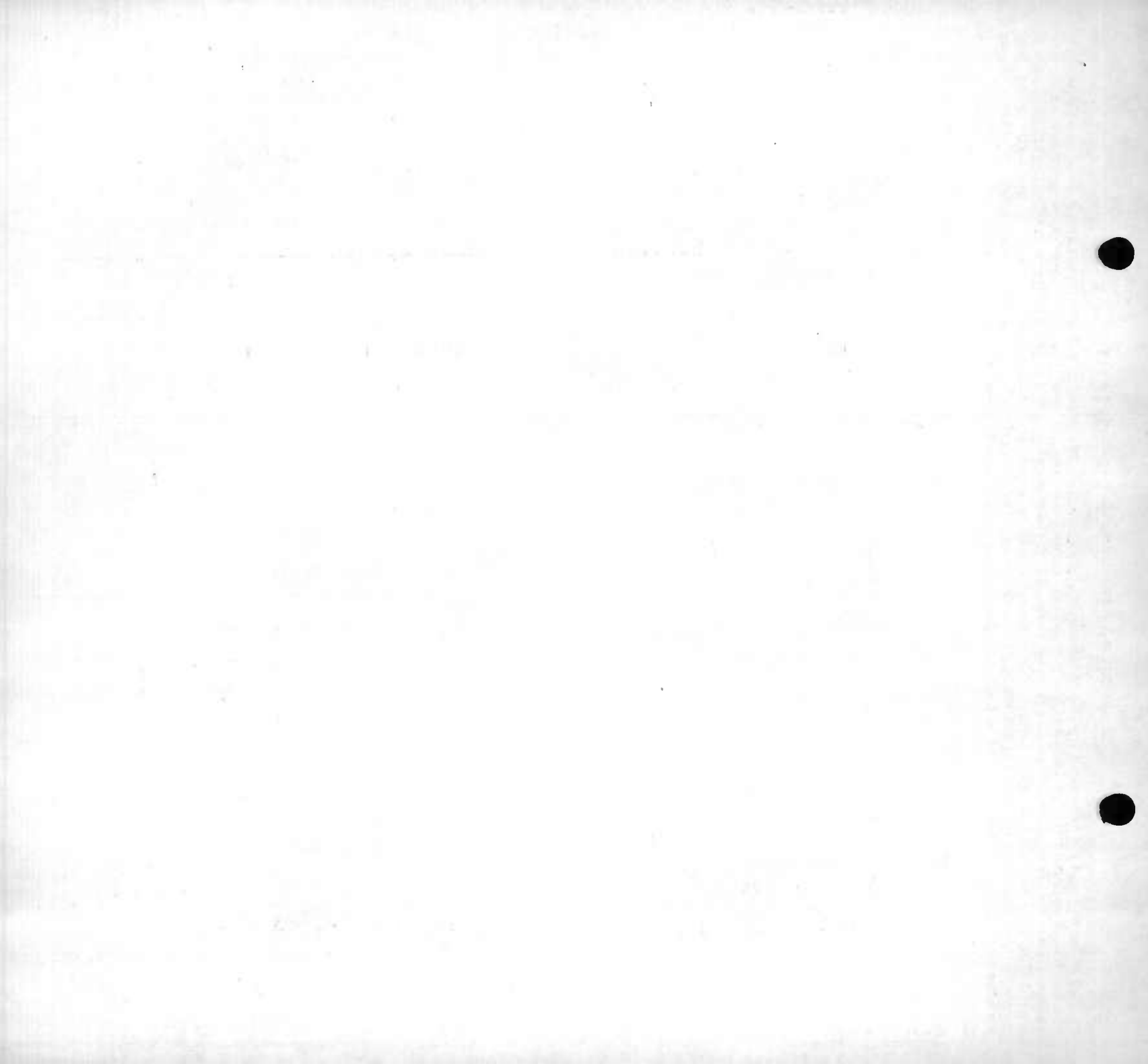
Essex

Scots or

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6490		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6490	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MILLS, Baby Girl		6/21/65		5:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
JOHNS HOPKINS HOSPITAL		MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
		CHOPTANK		D. STREET ADDRESS (If rural, give location)	
				55-00	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
F	N	XXXXXX	6/20/65		14
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
JAMES MILLS		XXXX ELIZABETH MILLS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I		(A) Prematurity			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 6/20 19 65 to 6/21 19 65, that (1) (we) last saw the deceased alive on 6/20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Norman Post				6/21/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
NORMAN POST		JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Cremation 6/21		6/21		Johns Hopkins Hos.	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Baltimore Md.		JUN 22 1965		Robert E. Farkas	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 22 1965		Robert E. Farkas		HOSPITAL DISPOSAL	



BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. **65 6491** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **65 6491**

M.E. CASE NO. **K-320**

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
JACK KOTTS		6/19/65 10:55 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Sinai Hospital		Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
Sinai Hospital		Baltimore	
		D. STREET ADDRESS (If rural, give location)	
		4012 Main Ave.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
male	white	Widowed	June 14 1894
9. AGE (In years last birthday)		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
71			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
Maintenance		Railroad	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Russia		1st Papers	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Jacob Kotts		Unk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		233 09 3313	
17. INFORMANT		ADDRESS	
Walter Kotts		112 S Ann Street	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
Arteriosclerotic cardiovascular disease			
(A) DUE TO			
(B) DUE TO			
(C) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		no	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W.U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 6/19/65			
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	June 22 65	Hold Redeemer Cemetery	4430 Belair Road Md
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS	
JUN 22 1965	Robert E. Taylor, M.D.	The Dippel Brothers 1800 E Lombard St	

MAIL ROOM

Butler June 22 62 Holy Redeemer Cemetery 1430 Relief Road
The Upper Brothers 1800 E. Lombard St

222 09 3323 United States 112 2 Ave Street

Jacob Witten

Maintenance Railroad Bridge Int. Express

Moved June 14 1894

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 6492

BIRTH NO. 65 6492

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CLARENCE GOODE

2. DATE AND HOUR PRONOUNCED DEAD

6/18/65 11:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2022 Llewellyn Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec 17, 1895

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired stenographer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Washington Goode

14. MOTHER'S MAIDEN NAME

Lucinda Allen

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or doles of service)

Yes

World War II

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Julia Goode 2022 Llewellyn Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Bronchogenic carcinoma with metastases

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic cardiovascular disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

6/19/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

June 24, 1965

23C. NAME OF CEMETERY or CREMATORY

Baltimore Natl. Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 22 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Milton E. Edulene 1129 N. Calver St.

ADDRESS

WILLIAM BOYD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 6493	
BIRTH NO. 65 6493		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Emmett Jennings		2. DATE AND HOUR OF DEATH 6-18-65 3:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 812 NORTH CAROLINE STREET			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH 9-22-36	9. AGE (In years lost birthday) 29	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemp		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
13. FATHER'S NAME HARRY EMMETT		14. MOTHER'S MAIDEN NAME BAGBZ, MARY		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Jennings - 812 N. Caroline St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E962X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Aortic Aneurysm DUE TO (B) Buerger's Disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 4 mo. 5 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N.B.	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that we (this hospital) attended the deceased from 19 63 to 6/18/1965 , that we (we) last saw the deceased alive on 6/18/1965 and that my (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death.					
23A. SIGNATURE Kenneth E. Quickel		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/18/65	
23C. PHYSICIAN'S NAME (Type) QUICKEL, KENNETH JR.		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial June 24/65		24B. DATE		24C. NAME of CEMETERY or CREMATORY Appomattox County Va.	
25A. DATE REC'D BY HEALTH DEPT. JUN 22 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Joseph E. Elchman 1129 N. Caroline St.	

9/1/45 - Inception due to stab wound of abdominal
aorta - 8 yrs. ago - Corrected from letter
from J.H.H. Filed in Rev. of Prostatitis
American Med. Soc.

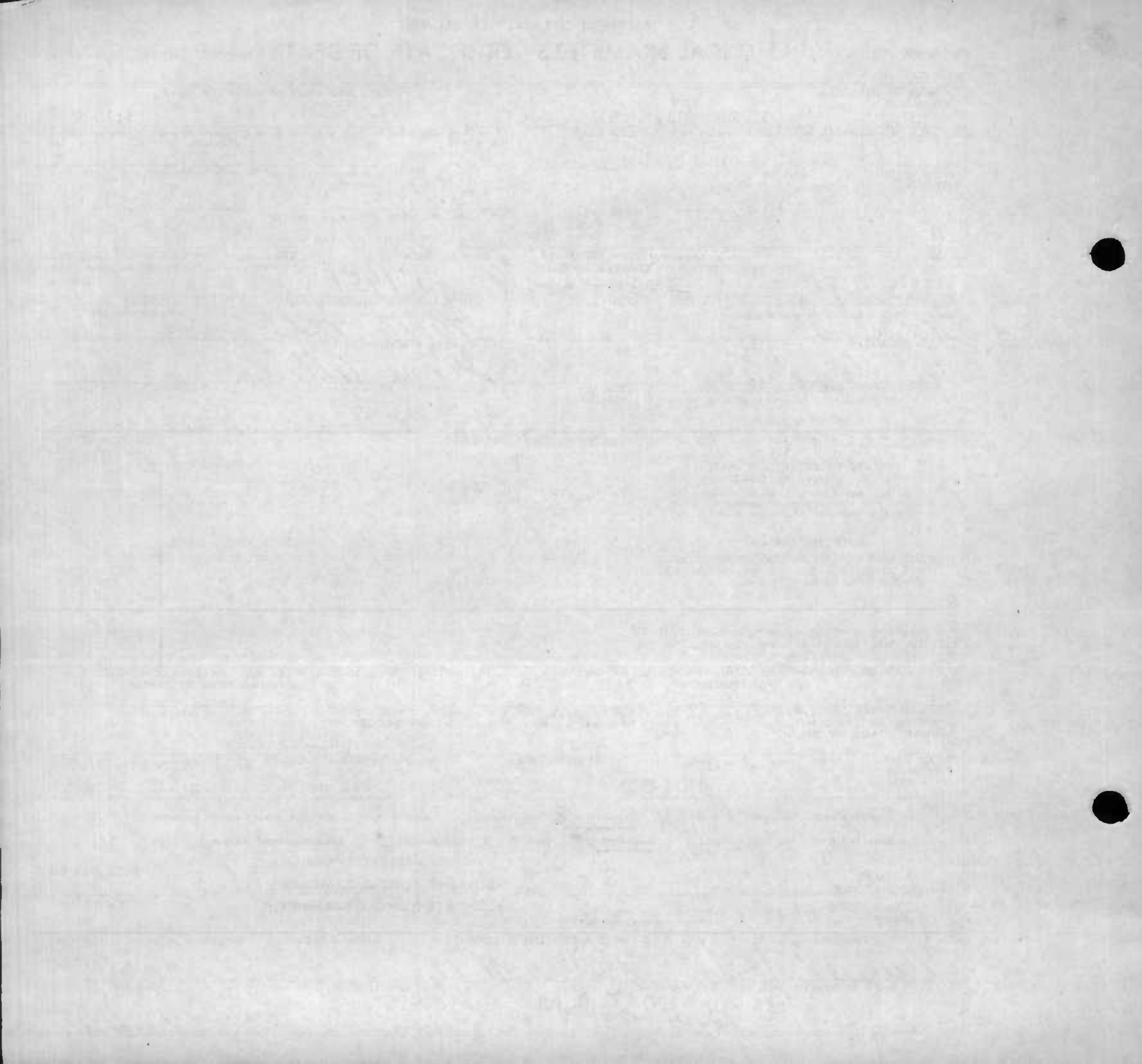
1
H 400

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 6494 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 6494

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
BRENDA ALLEN HILL		6-20-65 3:10 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 809 Bonaparte Avenue	
ST. JOSEPH'S HOSPITAL - DOA		9-08	
5. SEX	6. RACE	7. MARRIED / NEVER MARRIED / WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
Female	Colored		June 4, 1951
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)
Student			13
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Norman Hill		Irene Allen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
			Irene Hill 809 Bonaparte Ave.
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Depressed skull fracture			
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
			No
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
		Home	809 Bonaparte Avenue
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) 6 20 1965 PM		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	Fell from 2nd floor upper back porch when railing gave way
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) PETER W. RIECKERT, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	23C. NAME OF CEMETERY or CREMATORY
Burial		6/24/65	Bald. Hill Cem
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS
JUN 22, 1965		Robert E. Farber, M.D.	Milton E. Ellickson 1129 N. Charles



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 6495	
BIRTH NO. 65 6495										CERTIFICATE OF DEATH	
M.E. CASE NO.										2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) JAMES JEFFERSON										6/19/65 5 45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 LUTHERAN HOSPITAL										A. STATE B. COUNTY Maryland 15-03	
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baito.	
										D. STREET ADDRESS (If rural, give location) 1537 N. Benton ST.	
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 7/15/02		9. AGE (In years lost birthday) 62		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Glochuder County Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT chart			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 287X I CEREBRO VASCULAR ACCIDENT. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										INTERVAL BETWEEN ONSET AND DEATH 5 HOURS YEARS	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6/19 19 65 to 6/19 19 65, that (I) (we) last saw the deceased alive on 6/19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.											
23A. SIGNATURE Oscar Fernandez										23B. DATE SIGNED 6/19/65	
23C. PHYSICIAN'S NAME (Type) OSCAR FERNANDINI										23D. ADDRESS LUTHERAN HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6/23/65		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park				24D. LOCATION (City, town, or county) (State) Arbutus md			
25A. DATE REC'D BY HEALTH DEPT. JUN 22 1965				25B. NAME OF REGISTRAR Robert E. Johnson				25C. FUNERAL DIRECTOR ADDRESS Zeph T. Ellickson 1129 N. Caroline St			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 6496		REGISTERED NO. 65 6496	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) Mrs Minnie Stevenson				2. DATE AND HOUR OF DEATH 6-19-65 7:20 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 8-06			
FULL NAME OF HOSPITAL OR INSTITUTION Montebello State Hospital (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Beth 13			
				D. STREET ADDRESS (If rural, give location) 1620 No Washington St.			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 4-15-1900		9. AGE (In years lost birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Wimbor, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Smith				14. MOTHER'S MAIDEN NAME Minnie Smith			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Montebello S. Hospital	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Diabetes Mellitus				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-4-1965 to 6-19-1965 , that (I) (we) last saw the deceased alive on 6-19-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Orlando Ramos				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-19-65	
23C. PHYSICIAN NAME (Type) ORLANDO RAMOS				23D. ADDRESS Montebello S. Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) 6/24/1965		24B. DATE 6/24/1965		24C. NAME OF CEMETERY or CREMATORY Antietam Cal		24D. LOCATION (City, town, or county) (State) Beth 13 Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 22 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Elroy O. Wilson		ADDRESS 1000 Brandywine Dr	

9. 11. 1911

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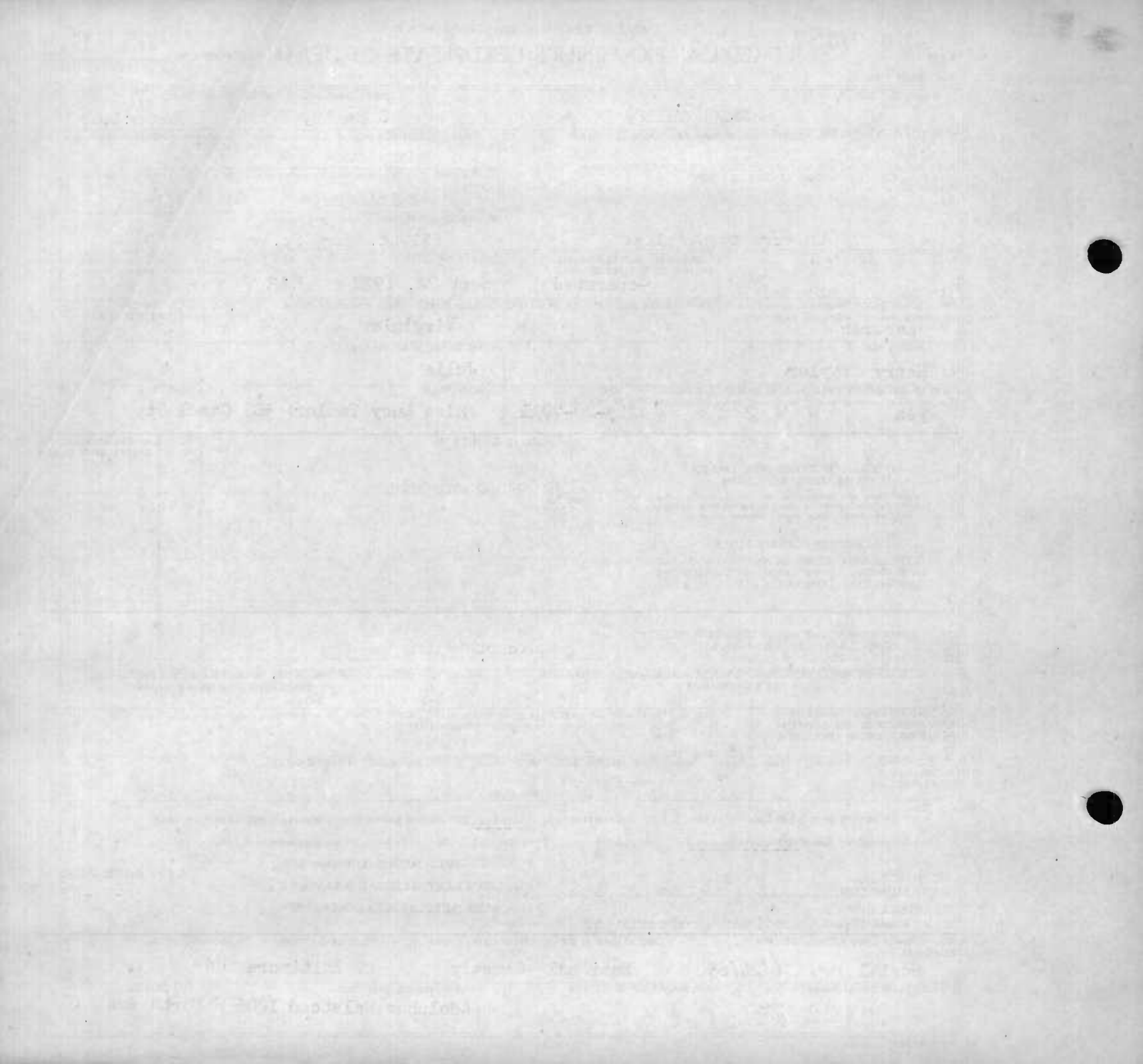
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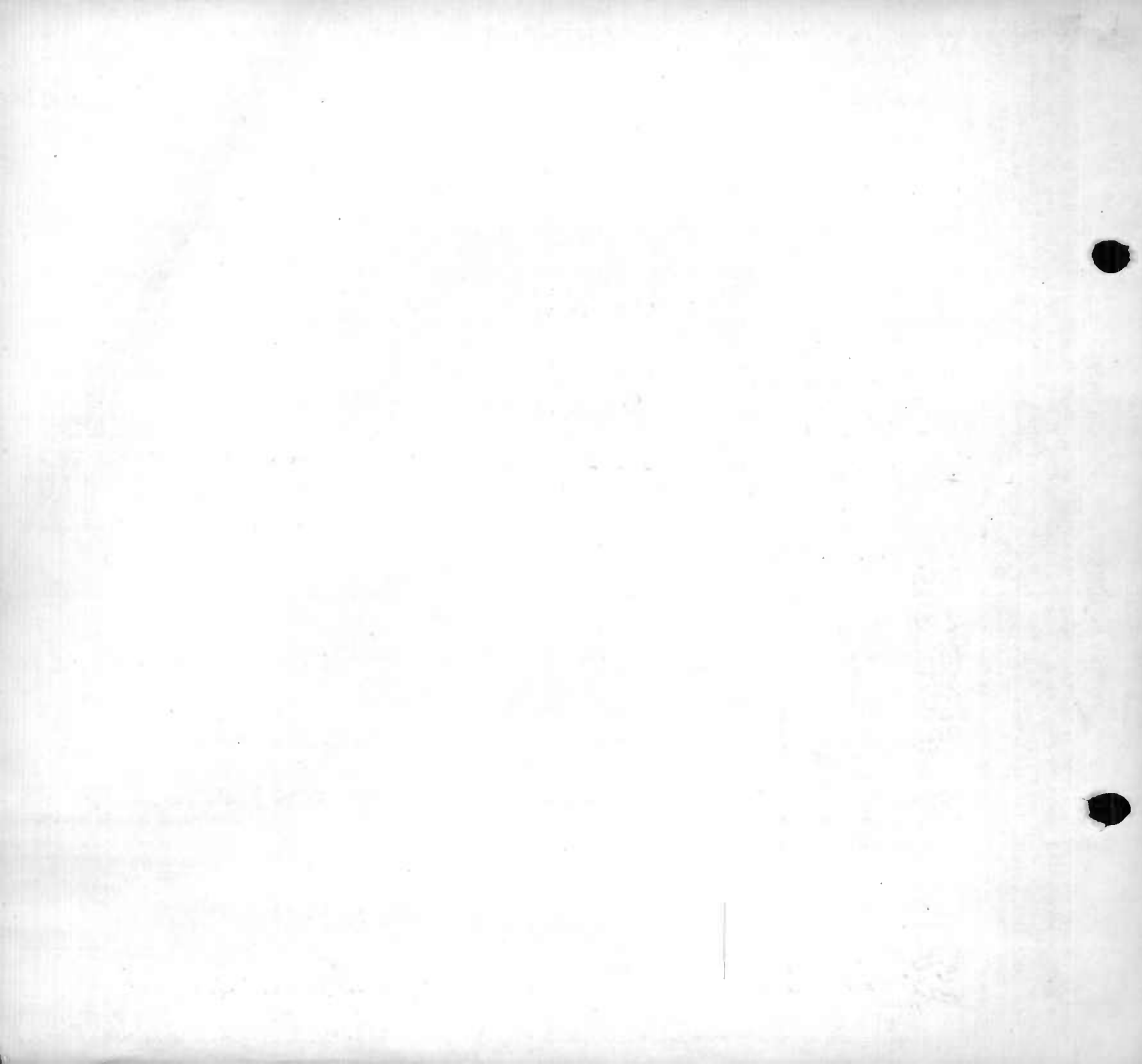
BIRTH NO. 65 6497		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 6497	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
		S. ASHTON TAYLOR		June 16, 1965 4:25 p M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY Maryland	
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-01	
				D. STREET ADDRESS (If rural, give location) 522 St. Mary St.	
5. SEX male	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH Sept 22, 1922	9. AGE (In years last birthday) 43	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Henry Taylor		14. MOTHER'S MAIDEN NAME Julia		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes W W 2		16. SOCIAL SECURITY NO. 225-20-7911		17. INFORMANT ADDRESS Miss Lucy Taulor 503 Camel St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 491X-322.0 I Bronchopneumonia		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Acute ethylism			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21F. HOW DID INJURY OCCUR?					
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breiteneker		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6-17-65	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6/24/65		23C. NAME of CEMETERY or CREMATORY National Cemetry	
				23D. LOCATION (City, town, or county) (State) Baltimore Md	
24A. DATE REC'D BY HEALTH DEPT. JUN 22 1965		24B. NAME OF REGISTRAR Robert E. Farley		24C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6498				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6498	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>HERBERT JONES</u>				2. DATE AND HOUR OF DEATH <u>6/21/65</u> <u>5 45</u> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>18-02</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 UNIVERSITY HOSPITAL</u> <u>BALTIMORE, MD</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location) <u>1211 W FAYETTE ST</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>3/18/17</u>	9. AGE (In years last birthday) <u>48</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Steel Mill</u>		11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SIMON</u>				14. MOTHER'S MAIDEN NAME <u>MARIA BELL</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>920-03-1320</u>		17. INFORMANT <u>PT</u>		ADDRESS	
18. <u>289.2/1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <u>CHRONIC RENAL FAILURE</u> DUE TO (B) <u>2. COLLAGEN DISEASE</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6/17</u> 19 <u>65</u> to <u>6/21</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>6/21</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Charles H. Asplen</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/21/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Charles H. Asplen</u>				23D. ADDRESS M.D. <u>University Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>6/23/1965</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Center Creek Church Cem. Blackstone Va.</u>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH/DEPT. <u>JUN 22 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Williams Funeral Home 319 N. Schenck St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 6499</u>	
BIRTH NO. <u>65 6499</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ROBERT TURNER</u>		2. DATE AND HOUR OF DEATH <u>JUNE 18, 1965</u> <u>6³⁰ P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 UNIVERSITY HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>ANNE ARUNDEL</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>GLEN BORNIE</u> <u>32-00</u> D. STREET ADDRESS (If rural, give location) <u>RTE 1 BOX 953 MARLEY WELIC RD.</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>5-12-93</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Glen Burnie Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Wesley Turner</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Gauthier</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Melanie Turner</u> ADDRESS	
18. <u>332X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>BRAIN STEM INFARCTION</u> DUE TO <u>HYPERTENSION</u> DUE TO <u>> 2 YEARS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>6/18/65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>10</u> (this hospital) attended the deceased from <u>11 AM</u> <u>6/18</u> 19 <u>65</u> to <u>6³⁰ PM</u> <u>6/18</u> 19 <u>65</u> , that (I) <u>last</u> saw the deceased alive on <u>6/18</u> 19 <u>65</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>Herbert A. Kushner</u> M.D.				23B. DATE SIGNED <u>6/18/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>HERBERT A. KUSHNER</u> M.D.				23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burned</u>		24B. DATE <u>6/23/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Marley Hill</u>	
24D. LOCATION (City, town, or county) (State) <u>Alle County</u> <u>Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 22 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>E. O. Wilson</u> 1000 Broadway Ave			

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Drum Stem Insertion
Hickory

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oil

HERBERT A. KOSMAN
Frank C. Jones
X
UNIVERSITY OF MICHIGAN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 6500		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 6500	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>STERN Mary</i>			2. DATE AND HOUR OF DEATH <i>6-19/65 2:30 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>34 Bon Secours Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balto</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Catonsville</i> D. STREET ADDRESS (If rural, give location) <i>1403 Midvale Rd 28</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED (specify)	B. DATE OF BIRTH <i>Nov. 14, 1891</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Jacob, John H.</i>			14. MOTHER'S MAIDEN NAME <i>Myers, Lilly</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT ADDRESS <i>Mrs. Lilly Volkman same as above</i>		
18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Hemorrhage</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Hypertension with Cerebral</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <i>Cerebral Hemorrhage</i> <i>Hypertension with Cerebral</i>		INTERVAL BETWEEN ONSET AND DEATH <i>19 hrs.</i> <i>many years</i>
19A. DATE OF OPERATION <i>June 19 1965</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <i>No</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>June 18 1965</i> to <i>June 19 1965</i> and that (I) (we) last saw the deceased alive on <i>June 18 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <i>Lester A. Wall, Jr.</i>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED <i>6/19/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>LESTER A. WALL, JR.</i>			23D. ADDRESS <i>1034 St Paul St 21202</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>6/22/1965</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Oheb Shalom Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 22 1965</i>	25B. NAME OF REGISTRAR <i>Robert E. Farber</i>	25C. FUNERAL DIRECTOR <i>Wm. F. Johnson & Sons</i>		ADDRESS <i>Balto. Md. 21217</i>	

